appeared. The patient's health rapidly improved, but no change took place in the damaged lens.

This is the first case of disease of the eyeball due to dental irritation with which I have met. I see cases of neuralgia in the neighbourhood of the eye very commonly, and cases of neuralgia of the eyeball less frequently, in which the cause is easily traceable to the teeth, the eye being perfectly healthy. The pain in some cases is attended with lachrymation; in a few with muscular twitchings of the face. The most frequent condition of the teeth giving rise to the neuralgia and other symptoms is caries, with exposure and chronic inflammation of the nerve. Patients are often unconscious of the condition of the teeth, the pain being distant and the teeth not aching. Touching the exposed nerve, or directing a stream of cold water on to the tooth, or into the cavity, will usually bring on a paroxysm of the distant pain and establish a diagnosis where doubt exists. Dental periostitis, exostosis, and necrosis, and also impacted lower wisdom-teeth, are less common causes of neuralgic pain.

From a paper lately read at the Odontological Society by Mr. Henry Power,² I learnt, with some surprise it must be confessed, that Mr. Power and numerous first-rate ophthalmic authorities, British and foreign, hold the opinion that dental lesions are very frequently the cause of serious diseases of the eye. Mr. Power lays it down as a maxim to be generally observed, that in all cases of threatening glaucoma, especially when this is associated with ciliary neurosis and obscure pains in the temples and maxillary orbital regions; in all cases of mydriasis, and probably of myosis, originating without apparent causes; in all cases of sudden paralysis of either of the orbital muscles, or of loss of sensation in the absence of cerebral symptoms; in all cases of phlyctenular disease of the conjunctiva; in all cases of ulcers of the cornea resisting ordinary treatment; in all cases of sudden failure of accommodation, especially in young children; and, finally, in cases of exophthalmia, the condition of the teeth should at least be examined, and, if faulty conditions present themselves, these should be at once rectified, and then one at least of the possible causes of each of these diseases will be removed. To this list must now be added cataract; for, although Mr. Power tells me he has not himself seen such an one, he accepts the case I have narrated as probably due to dental irritation.

Mr. Power gives many cases of his own and of other well known observers—Hermann Schmidt, Galezowski, and von Gräfe—in support of his opinions; and these opinions were corroborated by other ophthalmic surgeons in the discussion at the Odontological Society. Mr. Power points out the various ways in which diseased action about the teeth may reach the eye. These are (1) by inhibition; (2) by trophic or vaso-motor influence (under this heading Mr. Power would place my case); (3) by extension of neuritis; (4) by reflex irritation, or sympathy.

I must express no opinion upon these views; but I may repeat I have never, with the one exception, met with a case of eye-disease in which there seemed reason to suspect diseased teeth as a cause; that is, I have never had such a case referred to me as dental surgeon in hospital or in private practice.

I trust my case may be considered worthy of record and of discussion; and, in order to stimulate discussion, I have ventured to cite the recent *apropos* utterances of Mr. Henry Power.

TWO CASES OF EXCISION OF THE RECTUM.

By W. J. WALSHAM, F.R.C.S.,

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IN the BRITISH MEDICAL JOURNAL for April 28th, 1883, I published a case of successful removal of the rectum from carcinoma. Since then I have had two other cases under my care. In one, the growth was entirely removed, but the patient died on the fourth day after the operation. In the other, although I only partially succeeded in getting away the disease, the patient made an excellent recovery, and the distressing symptoms from which he had previously suffered were for the time completely relieved. As excision of the rectum is comparatively speaking a new operation, it would appear desirable that at present all cases, whether successful or unsuccessful, should be recorded. I, therefore, bring these under the notice of the profession.

CASE I. T. G., a man 54 years old, but looking older, came under my care at St. Bartholomew's Hospital, in the absence of Mr. Willett during the autumn vacation, suffering from malignant disease of the rectum. About eight months ago, he noticed an aching pain in the

sacrum, chiefly while passing a motion. Seven weeks, and again a fortnight ago, he passed blood *per anum*, and consulted Mr. McDonald, who, discovering the nature of disease, sent him to Mr. Willett as a favourable case for operation. The patient, although he said he had always enjoyed good health, looked weak and feeble. The anus was patulous, but there was no other external sign of disease. On passing the finger, a growth was discovered about two inches from the anus situated posteriorly and to the right, having a strip of healthy mucous membrane in front and to the left side. The growth was circular in shape, with a depressed centre, raised and indurated edges, and ulcerated surface. It appeared freely movable, but the finger could not be passed beyond it. The urine was neutral in reaction, its specific gravity was 1015, and it contained neither sugar, albumen, nor blood. As the upper boundaries of the growth could not be well defined, it was determined to examine under an anæsthetic, and to act accordingly.

On September 15th, the patient having been etherised and placed in the lithotomy-position, it was found that the growth could be drawn down, and healthy bowel reached beyond it. A full sized catheter was passed into the bladder, and Denonvillier's posterior incision made from the anus to the tip of the coccyx, and another carried along the junction of the skin and mucous membrane round the right margin of the anus to a point a little beyond the middle line in front. The rectum was then rapidly freed by the finger, and a few touches of the knife from the surrounding structures posteriorly and laterally, and more carefully anteriorly from the urethra and prostate. The disease being confined to the right side and posterior part of the bowel, the usual incision round the left margin of the anus was not made, but a strip of mucous membrane on the left side was left by severing the bowel longitudinally on either side of the disease with scissors, cutting carefully, and tying any bleeding points as they appeared. The growth having been thus freed laterally, was dragged down with vulsellum forceps, and separated from the bowel above with scissors. The hæmorrhage was free but excessive, and most of the vessels were secured by ligature; but as one or two could not be tied, the deep part of the wound in which they lay was plugged with lint, and a pair of pressure forceps left on one of them. No dressings were applied. Considerable collapse followed the operation; an ounce of brandy was administered on his return to the ward, and, on recovering from the collapse, twenty minims of tincture of opium.

On the 16th, the patient had passed a fair night, but the opium had to be repeated twice on account of pain in the hypogastric region. The plug of lint and pressure forceps were removed, and the wound, which was very foul, was syringed out with carbolic lotion (1 to 100). There was still some slight pain in the hypogastrium, but the abdomen was not tender, and moved in respiration. Fifteen minims of tincture of opium were ordered to be given every three hours whilst the patient was awake, and the wound to be irrigated every two hours with Condy's lotion. Pulse in the morning, 84; in the evening, 100. Temperature 9 A.M., 100°; 3 P.M., 101.8°; 8 P.M., 100.2°.

September 17th. He passed a restless night. There was still tenderness over the hypogastrium, and the abdomen was very tense. Breathing was purely thoracic; temperature, 9 A.M., 99°; 6 P.M., 97.2°; 9 P.M., 99.6°; pulse, 96, weak.

September 18th. The wound was very foul and discoloured, although it was washed out every two hours. The abdomen was still tender and tense, and the breathing thoracic. The temperature rose during the day to 101.4°, and the pulse from 108 to 130. He became gradually weaker, and died on the morning of the 19th.

At the *post mortem* examination, contrary to what was expected, there was no peritonitis. The peritoneum had not been injured, the wound being fully half an inch from the apex of the recto-vesical pouch. This pouch, however, contained several ounces of blood-stained fluid, and there was some discoloration and injection of the vessels in the neighbourhood of the wound. The wound itself was sloughy and foul. The disease had been completely removed by the operation. Several of the viscera were in a state of fatty degeneration.

CASE II.—A. B., a gentleman, aged 47, consulted me on October 29th, 1883. He said that, with the exception of an attack of piles, he had always enjoyed good health until six months ago, when he first began to suffer from pain during defæcation. He had never passed blood, but had noticed that his motions were small. He had lost latterly more than a stone in weight, but was still a stout muscular man. On examination, a firm, smooth, somewhat oval-shaped lump was found projecting into the rectum on its posterior and left lateral aspect, and about one inch and a half from the anus. It felt fairly circumscribed, but somewhat adherent to the parts beneath; the mucous membrane covering it was not ulcerated. The patient, with the exception of his rectal disease, was reported to be sound. I advised excision of the rectum. On November 20th I again saw him,

² "On the Relations between Dental Lesions and Diseases of the Eye," by Henry Power (*Trans. Odont. Soc.*, November, 1883).

and took him to Sir James Paget, who agreed with me that it was a favourable case for operation. On November 26th, the patient having been put under gas and ether, and a catheter introduced into the bladder, a digital examination was made, and as the finger could be passed well beyond the growth, which appeared circumscribed, it was resolved to undertake the operation, notwithstanding that there was some well marked induration beneath the mucous membrane. Denonvilliers' posterior incision was first made; two lateral incisions at the junction of the mucous membrane and skin were then carried two-thirds of the distance around the anus. The bowel having been freed from the structures forming the ischio-rectal fossa on the left side, a curved needle was carried up the wound and passed into the bowel, and the thread brought out through the anus. By this means, the cord of the écraseur having been passed, the wall of the bowel was severed in a longitudinal direction. The same proceeding was repeated on the right side. The écraseur was now passed transversely above the disease, and the portion of rectum removed. It was now found that the growth had extended beyond the coats of the bowel, infiltrating the tissues of the left side. As much of this infiltrated tissue was removed as possible, and a stout whipcord placed on the remainder, in order that it might slough away.

The patient suffered from exceedingly little shock, and made an uninterrupted and excellent recovery. His temperature never rose above 101°. He had no pain, and by the end of the first week, was up and on the sofa, and, by the end of the month, was taking carriage-exercise. The wound healed kindly, and, when examined (January 10th), the passage was found free, and full-sized motions were passed without pain; but some induration was felt under the mucous membrane; but the latter was smooth, and not ulcerated. A tube had been worn since a fortnight after the operation, and it was ordered to be continued for two or three hours daily. The patient had gained several pounds in weight; but, when last heard of, he was again beginning to lose flesh, and showed signs of a return of the disease.

REMARKS.—Both of the above cases appeared very favourable ones for operation, as the growth in each was confined to the posterior wall of the rectum, and was fairly movable; and the patients, although one was rather feeble, had apparently no visceral trouble. The first case offers a good example of the value of making an examination under chloroform before pronouncing an opinion on the removability of the growth. On the ordinary examination, it appeared as if the finger could not be passed beyond the disease; but, with the patient under chloroform in the lithotomy-position, the difference the parts presented was striking. The growth could now be easily drawn down, and a good inch of healthy mucous membrane felt above it. Although there are other important points to be taken into account when considering the propriety of removing the lower end of the rectum, I question whether, if all patients with the disease were examined in this way, the operation of removal would not much more often be undertaken than at present.

Free drainage of the wound and early irrigation cannot be too strongly insisted upon. The first patient died apparently from septic absorption. It is to be feared that this, in some measure, may be attributed to the wound having been plugged with lint for the first twenty-four hours, for the purpose of arresting hæmorrhage from vessels in the deeper part which could not be tied. On removal of the lint, the wound was very foul; and, although it was subsequently irrigated every two hours, it never became thoroughly sweet. In the second case, as well as in a previous one under my care, no dressings were applied, and the parts were freely irrigated from the first. In a future case, I would on no account plug, but try to secure vessels which could not be tied by forcipressure.

The second patient unfortunately delayed having the operation performed for a full month after he was first seen, and there is no doubt that during this time the carcinoma had made considerable progress. Although the whole disease in this case was not removed, so much comfort was gained, that it seems a question whether the well established surgical principle of not interfering with a malignant growth, unless the whole can be extirpated, might not be departed from in the case of carcinoma of the rectum.

TRANSFIXION OF THE HEART.—A case in which the heart was probably transfixed by a large steel shawl-pin, 3½ inches long, is reported in the *Edinburgh Medical Journal*. The patient was a lady, aged 56, with strong suicidal tendency. The symptoms were unconsciousness, widely dilated pupils, rolling of the head, paralysis of the left side, feeble radial pulse on both sides, and slight vomiting. Removal of the needle was followed by rapid recovery. No mention is made of any movement communicated by the heart to the needle, which was buried in the chest, for 2½ inches, at the situation of the apex-beat.

SURGICAL MEMORANDA.

PAINFUL AFFECTIONS OF THE RECTUM.

In one of Dr. Clifford Allbutt's Gulstonian lectures, he refers to a paper of my father's, upon painful affections of the rectum, and as bearing upon this question I desire to record the following case, which may prove of value to others, who meet with cases suffering from similar symptoms.

A gentleman, Mr. L., came to Harrogate on March 20th, to consult my father, on account of biliary derangement, constipation, and slight nervous irritability; he also complained of great pain at the anus, which shot up the rectum, and which he described as a biting burning pain. This pain was intense after each act of defæcation, and lasted a time varying from a few minutes to half-an-hour.

He had been operated on last Christmas for external hæmorrhoids; and on examination two hypertrophied folds of mucous membrane were visible, and adjoining these were two superficial fissures; I touched both the fissures with an ethereal solution of iodoform, and both healed up well.

On March 27th he still complained of pain, although not so severe, and his general health had much improved, under the course of sulphur-water and baths. On March 31st, the rectal pain still being severe, I made a thorough examination under chloroform; I found the bowel quite healthy, but there was a spasmodic stricture of the sphincter ani, to such an extent that it only admitted my forefinger with difficulty; this I at once broke up, by means of manual stretching, so that I could pass three fingers with ease.

The result of this slight operation was highly satisfactory, as he had no more pain of the biting burning character, even after a motion of full size.

On April 10th he consulted me about a slight pain at the anus, and, on examination, I found a small superficial submucous abscess. This I destroyed by means of my finger, and applied an ointment of iodoform and vaseline. He experienced no further pain or inconvenience after the act of defæcation, and left Harrogate three days later, altogether better and happier than he had been for months.

The good result of such a simple mode of proceeding in spasmodic stricture, as the stretching of the sphincter ani by manual force, is a point which deserves publicity. It would be well if the surgeon, whilst operating for hæmorrhoids, examined the condition of the sphincter ani at the same time, as very commonly some degree of spasm is the usual accompaniment of piles, and unless overcome at the time, renders a second operation absolutely necessary.

A. SCOTT MYRTLE, M.B., C.M.

IMPERFORATE HYMEN OPENED WITHOUT ANTISEPTIC PRECAUTIONS.

In the *JOURNAL* of May 3rd, a case is reported from the Bristol General Infirmary of imperforate hymen operated on with strict antiseptic precautions. Under the impression that it is not yet a sufficiently proven fact that these strict antiseptic precautions are the efficient causes of success, I have reported the following case, where no spray whatever was used, and where the discharge escaped with free access of air, and yet there was not a single bad symptom. It seems only possible to arrive at the real truth by a comparison of large numbers of cases treated by different methods.

E. S., aged 16, a servant, had never menstruated, although she was a well formed girl. She had, however, suffered from pain at distinct intervals, and, when she sent for me, her mother said she had been in severe pain all the previous night, and was then so bad that she was rolling on the bed, and that the womb had come down externally. On examination there was a distinct bluish projecting membrane, with marked fluctuation; the only opening to be found was that of the urethra. A triangular piece was removed from the centre of the membrane, and there was an immediate rush of a considerable quantity of dark coloured discharge, with instant relief from the pain, which did not recur. When the discharge had ceased, the parts were covered with a piece of linen rag soaked in carbolic acid lotion (1 in 40), and this was ordered to be continued; but, as often happens in this class, the mother was somewhat careless, the rag was allowed to dry or to fall off, so that we may fairly say that there was a free access of non-carbolised air. She was kept in bed during the remainder of the day and the next, but there was no rise of temperature, and then she was allowed to get up and resume her work, which she did without any bad effects.

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MEDICAL MAGISTRATE.—Dr. George Henry Evans, of Leigh, has been placed on the Commission of the Peace for Lancashire.