CASE I.—Emma W., aged 29, was admitted January 16th, 1885. She first noticed her sight failing twelve months ago. The left eye was worse than the right. An operation was performed on the left eye, and vision was much improved by it. On admission, she had conical cornea, well marked in both eyes. Iridectomy had been performed in the left, and there was a dense corneal opacity. The patient had never learned to read, and was very stupid. As far as could be ascertained, she counted fingers rather better with the right eye than the left.

January 19th. An elliptical piece was removed from the apex of the cone in the left eye, a 2 per cent. solution of eucaïne having been applied three times in ten minutes immediately before the operation. No pain was experienced; both eyes were strapped and bandaged.

January 29th. The eye was examined; the wound was leaking; the bandage was reapplied.

February 2nd. The wound was healed. There was no synechia.

February 9th. The right eye was operated on in the same manner. A drop of solution of eserine (4 grains to an ounce) was placed between the lids.

By February 27th, the wound had firmly healed, but there was an anterior synechia.

March 9th. There was nearly central corneal opacity in both eyes. She could see to thread a large sewing-needle with each eye.

CASE II.—Mary A. J., aged 15, was admitted on May 27th, 1885. Sight had been failing for years. On admission, she had well marked conical cornea in both eyes. The right eye read Jäger 8, a word here and there at two inches. The left eye read Jäger 4 badly at three inches.

June 1st. Eucaïne was applied, and the apex of the cone removed in the right eye. The lids were closed with strapping and bandage.

June 10th. The eye was opened; the wound was healed.

June 22nd. The left eye was operated on in the same manner; and the same treatment was adopted. Ten days later, the wound had healed.

July 21st. In both eyes, the pupils were circular and active; there were small nearly central leucomata. In the right eye, vision was $\frac{5}{8}$, not improved by lenses; it read Jäger 6 at six inches badly. In the left eye, vision was $\frac{5}{8}$ c—36 $\frac{3}{4}$; it read Jäger 2 at ten inches easily.

ABSCESS OF THE LUNG, PRODUCED BY SWALLOWING A PIECE OF GRASS: RECOVERY.

Read before the York Medical Society.

By RICHARD PETCH, M.D., York.

THE following case, which I believe to be unique, will doubtless be interesting.

S. M. P., a girl, aged 3 $\frac{1}{2}$, was subject to attacks of bronchitis, but otherwise strong. On June 29th, 1883, she was walking in the fields with her mother, when the latter heard her coughing violently, and crying out that she had something in her throat. Turning quickly to see what was the matter, she found the child gasping, and apparently on the point of choking. On looking in her mouth, she saw what she took to be a piece of grass behind her tongue; but, owing to the child's struggles, she was unable to get hold of it, and it seemed to disappear, being, as she thought, swallowed. For the rest of the day, the child coughed a great deal—an irritable dry cough—and complained of her throat hurting her. This continued two or three days, and she also complained occasionally of a pain, as she said, in her stomach. The cough continued, but became less frequent and severe; there was no expectoration. She began to fall off in health, lost her appetite, was thirsty, had headache, and became thinner.

I saw her first on July 13th, when I found her suffering from fever (102°), frequent quick pulse (130), and accelerated respiration (30). On examining the lungs, I found, on the whole of the left side posteriorly and laterally, slight *râles*, and indistinct dulness, with impaired expansion; the right lung was normal. A few days later, she began to expectorate muco-purulent sputum, without blood. The sputum quickly became entirely purulent, and more copious; it also became offensive, and was brought up with a good deal of retching. Her breath became very offensive, permeating the whole room; and, after a coughing spell and ejection of horribly smelling pus, it was almost impossible to stay in the room until fumigation and a widely opened window had cleared off some of the odour.

August 5th. She spat up a small piece of grass.

August 11th. We noticed a projection between the fifth and sixth left ribs in the axillary line; it was very painful, and respiration was absent over it. It gradually increased in size, and, on August 16th,

burst, and let out, along with a good deal of offensive pus, a piece of grass, which seemed to be the flowering axis of one of the graminææ. It was about an inch and a half in length. After this, the abscess gradually diminished in size, the pus became less, and, by August 25th, had ceased running, the wound being apparently healed. She had no cough, pain, or fever; she began to eat, and slept well.

August 28th. She was not so well, complaining of pain over the site of the abscess on movement.

August 29th. The abscess was found to be filling again.

August 30th. The abscess burst, discharging a large quantity of healthy sweet pus, with no grass. After this, she continued to improve in health, but the abscess also still continued to discharge slightly, and, as it seemed to make no progress towards healing, on September 15th I gave her chloroform, and, exploring the sinus, found the probe pass to the depth of three inches into a cavity with rigid walls, giving the impression of the cartilaginous walls of one of the larger bronchial tubes. I advised her removal to the sea-side, where she improved immensely in health, the pus diminishing, which it continued to do until the end of November, when it ceased, and the wound finally healed.

I saw her in January 1884, when I found her perfectly well; and, on examining the chest, found respiration, etc., perfectly normal over the whole lung, and no shrinking of the chest-walls.

REMARKS.—This case strikingly illustrates the *vis medicatrix nature*, upon which we have so frequently to rely, and with such well merited confidence, especially in children. It appears that the piece of grass, having been drawn by inspiration into some small bronchial tube, set up inflammation in the tube and surrounding pulmonary tissue, and general hyperæmia of the lung. The localised inflammation, passing into abscess, and tending towards the surface, happily excited adhesive pleuritis, thus shutting off the pleural cavity from the entrance of pus, and consequent disastrous consequences.

Recovery, though tedious, but not excessively so, considering the disease, seems to be perfect; for over the site of the abscess, as indicated by the scar, respiration is perfect. I presume there is a narrow cicatrix of the lung occupying the site of the abscess, and that the surrounding lung has expanded so as to fill up its former situation.

Treatment, at first, when precise diagnosis was uncertain, merely symptomatic, consisted, when the nature of the affection was plain, of abundance of nourishment, assiduous poulticing and fomenting of the side (to which I ascribe no inconsiderable share in the favourable result), a free supply of fresh air, and aerial disinfection by, and antiseptic inhalations of, sanitas oil.

The employment of the trocar to evacuate the abscess was considered, and mentioned to the parents, who strongly objected to any interference; and I did not at all press it upon them, as, seeing the continued favourable progress of the disease, I was inclined to trust to nature, and further, was doubtful whether I should be enabled by the trocar to withdraw the grass, the *fons et origo mali*, without which the operation would be useless. For the former reason, I was still less inclined to the use of the knife, although doubtless in some cases it would be the better treatment.

SEQUEL TO A CASE OF TREPHINING.

By GEORGE WHERRY, M.C., F.R.C.S.,

Surgeon to Addenbrooke's Hospital, Cambridge.

THIS was a case of comminuted depressed fracture of the right parietal bone in a man aged 25, who was struck on the head by a lunatic with a carpenter's mallet.

Trephining for removal of the fragments was performed by me six days after the injury, when hemiplegia and fever had supervened. An account of the operation and the progress to recovery will be found in this JOURNAL, April 21st, 1883, p. 767. The patient passed through many vicissitudes, including left hemiplegia, convulsive movement of the right side, severe headaches, fits of an epileptic character, and a period of undoubted insanity; nevertheless, he made a perfect recovery from all these evil symptoms, and followed farming pursuits during about two years. There was always an unfortunate difficulty in making him abstain from stimulants. In May, 1884 (more than two years after the injury), he had an epileptic fit, was violent at times, and had insane delusions. He rallied so far as to continue his farming business, but was thought to be weaker both in mind and in body. On July 6th, he attended some village sports. It was a hot day; he partook of beer, and walked home about two miles. Next morning, the fits came on. He passed into the epileptic state of continually recurring fits, which lasted six days, until he died on July 13th, 1884.

The family-history is remarkable. The patient's brother died in the epileptic state, said to have been brought on by drink, and his father committed suicide.

At the *post mortem* examination, there was an oval deficiency found in the skull-cap, between the right parietal eminence and the sagittal suture. The scalp corresponding was adherent to the dura mater, which membrane was thick, strong, and everywhere adherent to the edges of the gap. The brain-matter beneath, to the depth of a quarter of an inch, was almost in a purulent state, and, deeper, was discoloured and softened. The portion of skull showing the repaired fracture is preserved in the Cambridge Museum.

This account is from information kindly given me by Mr. De Lisle, of the Three Counties Asylum at Arlesey.

REMARKS.—At the time of the operation, it was noted that, except in connection with the superior longitudinal sinus, the dura mater was not torn; but the bone-fragments were driven in so deeply, that the brain-tissue beneath must have been badly damaged; and this, it seems probable, never recovered nor healed soundly, but remained of low vitality, and slight provocation broke down its softened tissues, and inflamed the regions round about.

A second operation, to relieve the injured brain-surface of inflammatory products, might perhaps have given another period of apparent health; but a tendency to drink, and hereditary disposition to brain-disorder, would have made a good result improbable. After head-injuries, it is especially necessary to avoid all stimulating drinks; and exposure to the sun seems certainly, in some cases, to have determined a fatal attack.

THERAPEUTIC MEMORANDA.

ON DYSPNŒA PRODUCED BY PELARGONIUM GROSSULARIODES.

THIS plant, which has been introduced from South Africa, now grows in a semi-wild state in the hill-station of Ootacamund (the chief town on the Nilgiris), where, at an elevation of 7,500 feet above the sea-level, it enjoys a semi-temperate climate. Its favourite habitats are dry-earth fences; and, when moist with dew or rain, it gives out a strong balmy odour, which can be perceived at some distance. To most people, this smell is agreeable, but, in the case of a lady who came under my observation, it immediately produced marked dyspnoea. At first, as the plant was in flower, I was disposed to think that this disagreeable effect might be due to the specific influence of the pollen-grains, as in hay-fever, but subsequent observation led me to conclude that it was purely the result of the effluvia of the leaves. Thus, when some of the plant not in flower was brought into the verandah of the room in which the lady was sitting, the usual effect was produced as soon as the smell made her aware of its presence. On several occasions, specimens were brought in without giving her any warning, and always with the same result. It further occurred to me that the dyspnoea could not be due to pollen or any very permanent particles, as the effect was transient, ceasing in about a minute after the removal of the exciting cause. While it lasted, the attack was rather sharp, and attended with a feeling of anxiety about the præcordia. Her great susceptibility to the smell was also remarkable, as she would often, when driving or walking, announce the proximity of her enemy, when the plant was not visible to the eye, and when its odour was not noticed by others till their attention was directed to its presence. This is, therefore, a fresh example of an idiosyncrasy of olfaction, of which numerous others are on record.

G. BIDIE, M.B., C.I.E.,

Deputy Surgeon-General, East Nook, Madras.

OBSTETRIC MEMORANDA.

VAGINAL EXTIRPATION OF THE UTERUS.

WHILST congratulating Mr. Jennings on his successful case of the above (which is noted in the JOURNAL of November 14th), and looking forward with interest to the detailed account promised later on, I venture to protest against this operation being performed for cancer of the cervix.

In a paper which I read before the Obstetrical Society last January (a short abstract of which appeared in the JOURNAL of February 7th), I proved that vaginal extirpation had a mortality of 28.6 per cent., whereas supravaginal amputation had a mortality of only about 7 per cent., and that the ultimate results of the two operations were precisely alike; namely, that 32 per cent. were free from recurrence two years later. Now, looking at these facts, and seeing that in the very im-

portant debate which ensued (and which had to be adjourned, as many Fellows wished to speak) there was a remarkable unanimity of opinion adverse to extirpation in cancer of the cervix, expressed by such men as Braxton Hicks, Priestley, Graily Hewitt, Playfair, John Williams, Sir Spencer Wells, Sir William Mac Cormac, Galabin, Knowsley Thornton, and Doran, is it not a matter of regret that any surgeon in this country should have felt he was acting in the best interests of his patient by performing this particular operation? In conclusion, I will make two abstracts bearing on this important subject; the first (a) consists of the sentence at the end of a leading article on Extirpation of the Entire Uterus, in the *Lancet* of March 14th; and the second (b) comprises the concluding words of my paper above referred to, which will be published *in extenso* in the forthcoming volume of the Obstetrical Society's *Transactions*. a. "The facts known unequivocally condemn total extirpation for cancer of the cervix, and are decidedly unfavourable to its practice for cancer of the body of the uterus." b. "But in all cases of cancer affecting the portio vaginalis, and, *a fortiori*, when there is the least implication of the vaginal walls, it appears to me to be an unjustifiable proceeding for us to subject our patients to the immense immediate risks which total ablation of the uterus entails, when we can positively gain quite as good ultimate results from an operation (that is, supravaginal amputation), the immediate risks to life from which are four times less."

WILLIAM A. DUNCAN, M.D., F.R.C.S., Harley Street.

RETENTION OF BROKEN GLASS IN THE VAGINA FOR SEVEN MONTHS.

ON October 19th, I was called in to see Mrs. F., aged 47, who informed me that about five years ago, when in London, she consulted a physician, who told her that some displacement of the womb existed; but, under the treatment adopted then, relief was soon obtained.

Menstruation having ceased for the last six months, and some slight return of the old symptoms being felt, she requested me to make the necessary examination. On introducing the forefinger of right hand into vagina, it came upon a hard round body lying to the right and posterior side of the cervix uteri. It felt firmly fixed, but, after some patient manipulation, became dislodged, and, to my astonishment, proved to be the broad perforated end of a broken glass female syringe.

The patient was amazed, and, upon my questioning her with regard to it, said that, about seven months ago, she broke a syringe when using a vaginal injection, but, hearing her husband coming upstairs, put the fragments into the chamber-utensil, and thought no more about it.

Copulation has been performed many times since then, the husband complaining of feeling some obstruction. The position of the foreign body had become exactly reversed, as the sharp point was lying upwards in the posterior vaginal wall, the convex blunt end of the syringe, with its numerous perforations downwards, and, as mentioned before, being moulded to the right posterior side of the cervix. How such a sharp pointed body became reversed and worn so long without injury to the vagina, and comparatively little discomfort, is most singular.

J. ACWORTH ANGUS, M.R.C.S., etc.,

North Ashfield, Newcastle-upon-Tyne.

SURGICAL MEMORANDA.

THE PLACE OF EXPLORATORY INCISION IN ABDOMINAL SURGERY.

IN the BRITISH MEDICAL JOURNAL of November 14th, two men of acknowledged eminence, Mr. T. Pridgin Teale and Mr. Lawson Tait, regard exploratory incision as a safe proceeding. There is, moreover, a consensus of opinion that it is so. This being so, I venture to bring before the profession a suggestion that has for long occupied my mind. Is it not a fact that, in all cases of abdominal or pelvic tumour, calling for operative interference, no one—not even a Keith, a Tait, or a Wells—can be sure, until the exploratory incision has actually taken place, what the state of things will be, and what steps, after the incision, will be necessary? Therefore, is it wise, and is it doing full justice to the patient, to go to the attack practically blind-fold?

Let me put the question in another way: Is not the peace of mind of the surgeon, on approaching an operation of magnitude, and during its performance, in the exact ratio of the time—hours or days—he has