two fingers being easily inserted into the rectum without causing any discomfort. There had been marked prolapse, and this was only slightly improved. His general condition was poor.

Perhaps the most striking case was one where the man had suffered for fifteen years, and it was with some difficulty that he was persuaded to submit to out-patient treatment as he was determined to have the operation performed. For some years he had been forced to wear a support to prevent prolapse of the rectum whilst walking. The mucous membrane was seen to be very markedly prolapsed and several piles were present, the anterior pile being the size of a walnut and the left lateral the size of a very large Brazil nut. The latter after two injections was completely thrombosed and the anterior after three injections. Prolapse soon disappeared, the anal orifice became normal, the sphincters regained their tone, and no stricture of the canal has developed.

Before subjecting a patient to this treatment he should be as thoroughly examined as if a major operation were to be performed. I would strongly insist on this, as the only death with which I am acquainted occurred in a case of advanced Bright's disease. Too much carbolic should not be injected—2 to 5 minims of the mixture is sufficient to inject into a pile at one time—and not more than three piles should be treated on any one occasion. If large amounts of carbolic are injected carboloria may result. Bright's disease, diabetes, pernicious anaemia, advanced cardiac disease, hemiplegia, and epilepsy are all contra-indications.

The advantages of the method are that it is almost painless—some nervous patients (especially women) complain of pain for some time afterwards, but this is very rarely severe; no anaesthetic is required; and the treatment can be carried through from beginning to end without the patient being incapacitated or his daily routine interfered with.

Since completing this series, I have tried the effect of injecting 30 per cent. sodium salicylate into piles. The results of the few cases (40) thus treated are as good as those treated with carbolic acid, but the pain immediately after injection is more severe and lasts longer.

HAEMOPHTHALMUS IN ASSOCIATION WITH TUBERCULOUS FOCI IN THE CHOROID.

BY

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It may be said that the diagnosis of tuberculous inflammation of the middle coat of the eye, assuredly a secondary infection, is a matter of more or less clinical probability. The family history and the personal history of the patient, together with the finding of a tuberculous lesion elsewhere and the exclusion of *Spirochaeta pallida* infection, form, as a rule, the basis of one's etiological belief. There is also that fallible but often trustworthy factor, clinical instinct. Not infrequently the primary focus remains undiscovered; and such aids as von Pirquet's skin reaction and Calmette's conjunctival reaction have not secured the allegiance of clinicians. A diagnostic help that may have unfavourable consequences in this relation is the hypodermic injection of Koch's old tuberculin. Its value is definite only if it be followed by the occurrence of irritation or an increase of irritation in the affected eye. But one cannot foresee how much irritation may arise, and it has happened that such an aggravation of the inflammation has been provoked that neither patient nor oculist was pleased with the mode of confirming the diagnosis.

CASE I.

Miss T., aged 26, had noticed, one week before visiting me, that the left eye was blind. She had lighted a candle in a dark room and, upon turning sideways towards the light, thought it had gone out. She then faced the lighted candle and, by closing each eye in turn, found that the left one was blind. When I examined this eye its pupil was inactive to direct illumination, there was a floating opacity in the vitreous humour, and the disc, which was scarcely recognizable, seemed to be enveloped in a bulky oedema with a

streak of haemorrhage on its surface. The floating opacity was situated in the centre of the vitreous and was so delimited as to allow of the red reflex being clearly seen all round it. The blood had been poured out into Cloquet's canal. Towards the nasal side of the disc was seen a patch of choroidal atrophy bordered by a line of dark pigment. The eye was blind. One month later I noted "floating opacities in the vitreous; pale disc indistinctly outlined; periphery of disc slightly prominent; arteries small." After five months the disc had the filled-in appearance, pale colour, and smudged edge of secondary optic atrophy. Immediately adjoining the lower border of the disc and spoiling its regular contour was a flat pale area about one-fourth of the disc's diameter in size. The right eye was normal.

Miss T.'s brother, aged 24, asked me to look at his right eye, which was not as good as the left. Below the right macular region were a sharply outlined, brilliantly white patch (almost as large as the disc) of choroidal atrophy and a tiny ill defined pale nodule alongside it. The visual acuity of this eye was 6/18; the other eye was normal.

Both brother and sister had always enjoyed good health. Miss T. declared herself to be somewhat run down, in consequence, she believed, of her nursing duties during her mother's last illness, which had terminated three months previously from heart failure. Their mother, over 70 at the time of her death, had suffered for years from a bronchial affection, which was said to be of a non-tuberculous nature. A sister of theirs, a child of 13, died of pulmonary tuberculosis.

CASE II.

E. B., a robust young woman of 24, noticed, a few days before coming to hospital, that the vision of the right eye had become greatly impaired. With this eye only shadows could be seen. The vitreous contained a large felt-like mass, which effectively obscured all details of the fundus. It was thought that a dimly seen glistening streak might be a tear in the retina. The other eye was normal. A general examination failed to reveal anything amiss. A differential blood count presented the normal picture. Rest, avoidance of stooping, and 5 grains of calcium lactate daily made up the treatment.

Three years later the patient returned to hospital on account of a simple phlyctenular conjunctivitis.

After her last visit she had remained in bed for one year! The vision of the right eye was 6/12, and of the left one 6/12 (partly). Far forwards in the vitreous chambers were seen floating knots and threads. Each fundus exhibited, at the periphery, the albinotic appearance seen after atrophy of the retinal pigment layer. There was in the right eye a patch of choroidal atrophy, and in the left one a raised focus at the junction of the lower and nasal borders of the disc. Engorged vessels were arched over the prominence.

Very often one sees in chronic tuberculous choroiditis foci in different stages of evolution. Some of the foci will have become atrophic patches, others will be recent, showing ill defined edges and raised forms. In the first case some support was given to the diagnosis of tuberculosis by the family history and the examination of the brother's eye. Both patients gave a negative Wassermann reaction. The phlyctenular conjunctivitis of the second case was not, in a pathological sense, out of place. But perhaps it is best to say that the opinion of the nature of the cases is the result of cumulative clinical impressions.

APPENDICITIS AND INTUSSUSCEPTION IN A DOG.

LYMPHATICOSTOMY FOR SEPTIC PERITONITIS.

BY

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THE publication of the following story of the illness, death, and *post-mortem* examination of a puppy may be justified not only as a contribution to comparative medicine, but by the fact that the conditions found raise some interesting general questions.

A terrier, aged 8½ weeks, when seen on November 8th, 1922, was in a state of extreme emaciation with a poor appetite, and hardly any of the liveliness of a puppy. The bowels, which were at first relaxed, later became constipated. Castor oil caused vomiting and loose actions, but did not clear the intestine. There was no abdominal distension nor definite evidence of pain on manipulation. On November 15th and 16th hard masses were felt towards the pelvis. On November 17th an enema induced a discharge of faeces tinged with blood, and death occurred on that day.

Autopsy showed an intussusception involving the last twenty-four inches of the small gut. The peritoneal surfaces at the distal