conditions of the eye mercury and potassium iodide are very uncertain in their action, sometimes much benefit resulting from their administration, and in other cases the results are nil.

I used this treatment in several cases, with much benefit, and in some patients who had previously been treated by other methods without good results; but in my experience the pilocarpin produced such profound depression when injected daily for ten or more days that I cast about to see if there was not some other method of stimulation of the ordinary physiological processes without this great drawback. In fact, in certain cases, the depression was so profound that the patients, although acknowledging their vision was better, refused to continue the treatment, remarking that the remedy was worse than the disease.

Of course the ordinary hot-air bath suggested itself, but was discarded as being too cumbersome, and finally guaiacol was recommended to me by a colleague. It is, I believe, not generally known that if a small quantity of guaiacol be smeared on the skin, profuse diaphoresis results in about one hour.

I have now tried this method in nearly 40 cases with most excellent results, irido-cyclitis, vitreous opacities, and interstitial keratitis seeming to be the most suitable conditions for the treatment.

The following is the routine usually employed: The urine is examined, and the mercury is omitted if any albumen is found. The ordinary alterative mixture of hydrarg. perchlorid. gr. $\frac{1}{8}$ and potas. iodid. gr. $\frac{1}{2}$ is given thrice daily; sometimes instead of the above hydrarg. creta gr. $\frac{1}{2}$ is given in a pill thrice daily, together with a mixture containing potassium iodide and tincture of nuxvomica. The patient is kept in bed between blankets with two hot-water bottles, then 1 drachm of a mixture of equal parts of olive oil and guaiacol is smeared, not rubbed, either in the axilla or over the epigastrium. If this dose does not suffice then 2 drachms are used, and in rare cases three, but mostly 1 drachm is enough. The part is covered with oil silk, and a pad of wool is applied over the silk. A hot drink is now given, and profuse general perspiration begins in from one to two hours and lasts for about five hours. It is difficult to make some patients perspire, and in these cases a hot bath beforehand assists and hastens diaphoresis. In one patient some irritation of the skin was produced by the guaiacol, but this was practically well in a week on ceasing the treatment; but the skin in this case was too irritable to stand the application on the same place two nights in succession.

Generally twelve applications are made, and then treatment is stopped for a few days and begun again if considered necessary. As a rule, the patients are kept in bed the whole time, but occasionally when the applications are made in the morning, I allow them to sit up for an hour or so in the evening, well wrapped up.

Our experience at the Shrewsbury Eye Hospital is that guaiacol is a far more certain diaphoretic than pilocarpin, and does not produce the after-depression of the latter drug, while the results are, as far as I can see, equally good.

I have not tried it in any very acute cases, but there does not seem any reason against its use in these conditions. Among the eye diseases for which this modification of the "combined" treatment has been used are interstitial keratitis, irido-cyclitis, vitreous opacities, sympathetic ophthalmia, and optic neuritis. In all there was some benefit, and in some the results were remarkably good. Very many of the patients had been previously treated with ordinary routine methods without good results. Certainly in syphilis the condition is more quickly controlled than when mercury and iodide are used alone. Recently I have been using this treatment in a case of syphilitic perichondritis of the larynx with very good results, when previously the use of mercury and potassium iodide has not influenced the condition very appreciably.

The idea of treating syphilis with diaphoretics and mercury is not new, but has, I believe, been carried out for some years, with the object of shortening the treatment.

REFERENCE.

¹ *The Combined Treatment of Diseases of the Eye.*

HYDATID DISEASE: RECURRENCE: EXTERNAL RUPTURE: RECOVERY.

By ARTHUR W. BRODRIBB, M.A., M.B. OXON., L.R.C.P.,
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In October, 1908, there were published¹ in this JOURNAL notes of a case under my care of hydatid disease in an old lady, in which the disease appeared to be situated in Douglas's pouch. Rupture occurred into the rectum and large numbers of hydatid cysts were discharged. Recovery followed, and for three months the patient seemed completely well.

On October 12th, 1908, I was called in again, as she was in great pain in the abdomen, and was shivering. The temperature was 101°, the pulse feeble, and respirations rapid. I found some sharp crepitations at the left base, and in the abdomen a tender swelling to the left of the umbilicus, dull to percussion, and about the size of a seven months' fetal head. It appeared probable that there was recurrence of the hydatid disease, and possibly some pneumonia setting in, as she was suffering also from a short, painful cough. There was no obstruction in the bowels, as in the former illness.

The next day she was better, the temperature 100°, and the cough and crepitations less. By October 16th the chest symptoms had disappeared, the temperature had fallen to 98°, and the pulse to 88, but the patient did not seem so well; the abdominal pain was greater and the abdomen decidedly larger, the tumour developing a resonant prominence to the left and below the umbilicus. In the left flank there was some resistance and impaired percussion note, and great tenderness.

During the next week her condition varied; at times the abdomen was enormously distended with flatulence, and the tumour was larger, the skin over it becoming red and oedematous. The whole of the left side of the abdomen and left flank was dull to percussion. On October 26th the prominence was much larger, the skin more angry in appearance, and she was extremely weak.

On October 29th she passed from the bowel about a pint of mud-coloured liquid, very offensive, but containing no cysts. The next day she passed another three-quarters of a pint, and was evidently relieved; the abdomen was smaller and less tender. During the next few days she seemed better, but the tumour began to increase again, and the condition of the skin became worse. On November 6th she was decidedly worse, and became delirious. Small beads of clear fluid began to ooze through the skin over the tumour from two minute holes. In this way large quantities of clear fluid came away during the next few days, the small holes developing into wounds half an inch long with jagged edges. No cysts were passed. The tumour became rapidly smaller, and the general condition of the patient improved. On November 11th, instead of clear fluid, white creamy very offensive pus was coming away. The wounds were beginning to heal, and an attempt was made to keep them open to get as much drainage as possible. The tumour no longer projected. Within ten days of the first discharge of liquid the tumour had disappeared, and no further discharge occurred. The wounds healed remarkably quickly. The patient made a rapid recovery, and is now in splendid health, in spite of her age, which I believe to be well over 80. She seems none the worse for her two severe illnesses.

The contrast between the two illnesses was chiefly marked by the different direction in which the cyst pointed. Probably the peritoneum was the seat of the trouble, and it may have been the same large cyst in each case, but in the first illness it pointed into the colon, which was almost blocked by it. This cyst refilled, and fortunately pointed, and burst, externally. An alternative view is that in the second illness an entirely new hydatid cyst developed, and the fluid was drained off through the abdominal wound, leaving the daughter cysts within where they have atrophied.

A hydatid cyst situated in the peritoneum can only point in four ways: (1) Into the gastro-intestinal tract; (2) into the bladder; (3) into the peritoneal cavity; (4) externally.

REFERENCE.

¹ BRITISH MEDICAL JOURNAL, vol. ii, 1908, p. 1271.

INTRA-ABDOMINAL HAEMORRHAGE ASSOCIATED WITH LABOUR.

By MAURICE C. BARBER, M.R.C.S. ENG., L.R.C.P. LOND.,
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THE intra-abdominal haemorrhage which occurred in the following case must, I think, be a very unusual complication of labour.

C. B., aged 32, enjoyed good health until the age of 15, when her mother says she was paralysed in both lower extremities for