pipette can be safely relied on to indicate an abnormally low surface tension with certainty, and to give an approximate idea of its value. As the pipette is of exceedingly simple construction and only measures a few inches in length, whilst the test can be carried out in a minute or two, it ought to prove of service as a convenient quantitative substitute for Hay's test.

In conclusion we have great pleasure in expressing our thanks to Mr. J. J. Macaulay, M.P.S.I., for valuable assistance rendered to us on several occasions.

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REMARKS ON A CASE OF DETACHMENT OF THE RETINA.*

By JAMES A. CRAIG, M.B., F.R.C.S. ENG.,
Assistant Ophthalmic Surgeon, Royal Victoria Hospital, Belfast.

THE case of retinal detachment which I propose to report to you is, I think, one of considerable interest. The treatment of detachment of the retina is, unfortunately, one of the most unsatisfactory in the whole range of ocular therapeutics, and the most diverse views are held by ophthalmic surgeons as to the value of different lines of treatment. While on the one hand some, and these mainly, I believe, Continental surgeons, persistently attack all cases of this affection coming under their notice by bold surgical measures, and are able to publish results which are on the whole encouraging—namely, results which go to show that in some cases the detached portion of retina can be restored to its original position, and kept there with a partial restoration of vision—there are others equally eminent who hold the most gloomy views as to the value of operative treatment, and even assert that they have never known a case where operative measures have effected a lasting cure. Some, indeed, condemn as specially inefficient the measures to which I attribute the success of this particular case, and in this connexion I may here point out that these measures were undertaken only after milder methods had been tried and had failed.

The case differs in some very important respects from the majority of those which have been reported. The chief points of difference are, first, the early recognition of the condition, which was effected before the central vision was impaired, which rendered possible the second, namely, that the patient still has full vision—that is, $\frac{6}{6}$. Most of the results which I have seen reported have been secured in patients whose vision had already been much impaired by the detachment and in whom recovery had necessarily been only partial.

The patient, H. A., came to me in July, 1903, complaining of an uncomfortable sensation in his left eye, which he described as being like the shimmer of strong light off the surface of moving water. This had been going on for three weeks previous to his coming to me, and as his sight in both eyes was quite good he did not attach any great importance to it, and, indeed, rather apologized for his visit, which he seemed to think was hardly necessary. There were no other symptoms and the vision in the eye was quite good.

On examination of the affected eye the field of vision was found to be defective below—namely, from a point 20 degrees from the fixation point to the periphery. Central vision was unaffected, the patient reading with full correction $\frac{6}{6}$. Examinations of the fundus revealed the presence of a clearly-marked detachment of the retina in the upper quadrant.

As regards the question of causation in this case, the patient had a myopia in the right eye of 9 D., with a slight astigmatism, and in the left (the affected eye) a myopia of 8 D. Myopia is, of course, the commonest predisposing cause of retinal detachment, but another possible factor in the case was the participation by the patient in a "tug-of-war" a week or two previously. Whether the strain involved in this severe physical effort was instrumental in actually determining the detachment must, I suppose, be doubtful.

The condition of affairs, with its very unfavourable prognosis, was communicated to the patient, and the possibility of cure by energetic treatment was offered. Although I was not at all sanguine of success, I felt that this was a case where there were many circumstances in the patient's favour. He was a young and healthy subject; the detachment was obviously recent, and there was no evidence of other intra-ocular disease. And I was encouraged to adopt active measures the more as the patient, who was of a highly-intellectual type, fully realized the gravity of the situation, and was plucky enough to face all the rigours of what promised to be rather drastic treatment, with only a faint hope of ultimate success.

He was admitted to a private nursing home and treatment was begun. The dorsal decubitus was instituted and rigidly adhered to, and in view of the possibility of cure by mild measures only, I tried a course of daily subconjunctival injections of 2 per cent. saline and diaphoresis by daily hypodermic injections of pilocarpine of gr. $\frac{1}{4}$. At this time he was seen by my colleague, Dr. J. W. Browne, in consultation, as I was anxious that no doubt should exist in the patient's mind as to the need for what he had found by this time to be very irksome treatment. Dr. Browne's opinion coincided with my own—that the case was one for active treatment, and that if the injections, diaphoresis, etc., failed, puncture might be tried.

At the end of a week no improvement had taken place. I then decided to perform evacuation of the subretinal fluid by scleral puncture, and effected this without much difficulty, using for the operation an ordinary iridectomy knife. The immediate effect was all that could be desired. The subretinal fluid came away freely, and examination of the eye immediately afterwards with the ophthalmoscope showed the originally grey detached retina back in position with its pink colour restored, the subjective sensation of a grey veil simultaneously disappearing. I followed the puncture by another subconjunctival injection and bandaged the eye firmly with a pressure bandage.

In four days, however, the retina again became detached, with return of the subjective phenomena, and I decided again to puncture and, in addition, to apply the galvano-cautery over the seat of operation, with the intention of setting up enough adhesive inflammations of the parts to fasten down the retina. This was done on the twelfth day from the institution of the treatment, and again the immediate effect was completely successful. For eight days after this the retina remained in position, and again the detachment recurred.

At this stage the patient was seen in consultation by my colleague Dr. Nelson. He considered that the former results of the operation had been so favourable as to justify a repetition of the procedure, and this was again done, now near the end of the fourth week from the beginning of the treatment. On this occasion I first dissected back a flap of conjunctiva in order to allow the puncture to be made so far back as possible, and the cautery was energetically used.

After this no signs of detachment again returned. As a precautionary measure, however, I thought it advisable to again apply the cautery at the end of a week in order to cause further inflammatory adhesions. On testing subjectively it was now found that there was a relative colour scotoma in that portion of the field corresponding to the seat of the detachment, that is to say, that colour sensations as determined by a blue test object were, according to the degree of illumination, confused or quite lost over this area, although the object itself could be seen.

Examination of the fundus showed slight opacity and one or two punctate deposits of exudate in the affected portion of the retina. The normal pinky appearance was, however, quite restored. More peripherally the position of the punctures and cauterizations could be easily seen as a deeply-scarred and pigmented surface.

The dorsal position was maintained for ten days further and then the patient was allowed to go home. Three weeks later the condition was still found quite satisfactory, central vision (corrected) being $\frac{6}{6}$, and the only visual defect being a relative colour scotoma over an area of the field extending from the 30th to 60th degree in the lower half. On November 16th this scotoma had so improved that the patient could appreciate colours, but blue appeared darker. The patient was last seen by me in April, 1905—that is, twenty months after the termination of treatment. Vision was still $\frac{6}{6}$, and no sign of detachment could be detected. I would call special attention to the following points in this case:

* Read at a meeting of the Ulster Branch of the British Medical Association.

1. The inefficiency of subconjunctival injections even in conjunction with rigid dorsal decubitus.
2. The prompt response to puncture, followed by the tendency to relapse, even while the decubitus was maintained.
3. To the effective result apparently obtained by the cautery, to which measure I indeed attribute the success of the result.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

TRAUMATIC PNEUMONIA.

THE notes by Dr. Forster in the *BRITISH MEDICAL JOURNAL*, December 9th, recalled to my mind a case in my charge when House-Surgeon in Ayr Hospital. The pneumonia not only followed an injury to the chest wall, but throughout its course presented an interesting and somewhat uncommon clinical picture.

R. K., aged 11, was admitted to hospital on April 28th, 1905, suffering from right-sided croupous pneumonia. The following history was obtained: On April 21st when out playing he fell and struck the lower part of the right side of his chest. Two days later he began to complain of pain on that side. No notice was taken for a day or so, as it was thought to be merely due to the bruising sustained in the fall. The pain, however, continued, his breathing became hurried and somewhat laboured, he lost his appetite and could not rest at night. A medical man was then called in, a diagnosis of pneumonia was made and he was removed to hospital on April 28th.

The diagnosis was confirmed on examination, the right lung (lower half) being the affected part. The temperature was 105° F. on admission, the crisis occurred on the ninth day, and in the acute stage the illness ran a fairly typical course.

During his convalescence, which was very prolonged, some interesting points were noted. On May 15th the temperature, after being normal for a week, rose to 101.8° F., and for the next ten days it varied from 99° to 102.8°. A careful examination of the chest was made, and over one limited area posteriorly there was increased vocal resonance and bronchial breathing. He had night sweats and was losing weight. The sputum was scanty and slightly purulent. On May 23rd antiphlogistine was applied, and two days later the temperature fell to normal. I examined the sputum for tubercle bacilli, but failed to see any. I sent up a specimen to the Clinical Research Association, London, for expert opinion, and I received the following report:

The sputum consists of blood-stained muco-pus, but no tubercle bacilli can be seen after prolonged examination.

The patient shortly afterwards began to make headway. His appetite was good and he gained in weight. On June 7th nothing abnormal in his lungs could be detected. He was allowed up a few days later, and was discharged on June 23rd, 1905. There was no history in this case of exposure to wet or cold, and the injury seems to have been the exciting cause.

Edinburgh.

JOHN ALLAN, M.B., Ch.B.

NASAL POLYPI AND ASTHMA.

IN connexion with the vexed question of a relationship between nasal polypi and asthma, the following case may be of interest:

Mrs. X., a lady past middle life, had suffered severely from asthma. She had had nasal polypi removed several times but they rapidly recurred, and it had been decided to try to relieve her by more radical treatment, for a diseased bone was obviously present in the ethmoid region. Dr. Gilmore (Brixton), whose patient she was, gave the anaesthetic (chloroform and ether), and I began by cauterizing the septum. This produced no obvious effect on the breathing, but immediately I applied the curette to the middle turbinate region a violent attack of typical asthmatic breathing came on, which at first was rather alarming. The operation, however, was continued and finished, and recovery was uneventful. *Post hoc*, of course, is not necessarily *propter hoc*, but it certainly appeared as though stirring up the seat of the polypi produced the attack.

London, W.

W. H. KELSON, F.R.C.S.Eng.

ABORTIFACIENTS.

DURING the comparatively short time that I have been in practice in this district I have met so many cases in which diachylon has been taken that I now invariably examine the gums of any female patient the nature of whose trouble is at all doubtful. In none of these cases have I seen wrist-drop, although some of them had been taking lead for several months. In one severe case with encephalopathy vomiting and optic trouble for two months, there was no sign of wrist-drop whatever.

Every young medical man fresh from hospital work should be on the look-out when he commences private practice for instances of attempted abortion by drug-taking. If he is, he will avoid much anxiety and trouble, and will never need to be saved from sending a patient to a hospital as a case of intestinal obstruction by a kindly neighbour's query: "Don't you think she has been taking something, Doctor?"

Belper.

G. BRITTON GILL.

REPORTS

ON

MEDICAL AND SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF THE BRITISH EMPIRE.

THE SICK CHILDREN'S HOSPITAL, NEWCASTLE-ON-TYNE.

A CASE OF OMENTAL CYST IN A BOY AGED 8 YEARS.

(Reported by PAUL MATHEWS, M.B., late Resident Medical Officer.)

THE following case appears one of such unusual interest that I venture to publish the notes in full.

J. N. F., a boy aged 8, was admitted to the Newcastle Sick Children's Hospital in October, 1904, with the following history. He had measles nine months previously, after which he began to complain of vague abdominal pain, chiefly in the left side. Gradual distension of the abdomen then set in, and continued until admission to hospital. He latterly suffered from considerable dyspnoea, at first on exertion only, then constantly. The pain subsided as the distension increased. There was no history of any previous illness or of trauma, and nothing of note was discovered in the family history.

State on Admission.—His general development was good, nutrition rather poor. There was no oedema or cyanosis, but slight dyspnoea. Abdominal tumidity was very marked, the general contour being globular. The superficial veins were distended, but no caput medusae was formed. Resistance to palpation was most marked in the centre and just above the umbilicus. The maximum circumference occurred 2 in. above this level, and was 27 in. The umbilicus was flattened, but not reddened. There was no pigmentation of the abdomen. The abdomen was not tender on palpation. Percussion gave absolute dullness everywhere except in the flanks and hypogastrium, where the note was tympanitic. The limits of dullness were not affected by alteration of posture. There was a well-marked fluid thrill. A few small glands were palpable low down in both axillae, in the groins, and in the supraclavicular triangle. The urine contained 0.1 per cent. of albumen, but no casts; reaction, acid. Examination of other organs revealed nothing of note.

Tapping.—October 10th. The abdomen was tapped in middle line below the umbilicus with a Southey's tube, and 84 oz. of fluid drawn off having the following characters: Opaque red-brown colour, alkaline reaction, specific gravity 1.024; did not coagulate on standing; heavy deposit of red blood cells, with few leucocytes and endothelial cells. On standing the deposit was bright red and the supernatant fluid olive green (opaque).

After tapping, the circumference of the abdomen was 21½ in., walls flaccid and permitting free palpation. The liver and spleen were not palpable, and there was no sign of enlargement of either organ. An indistinct mass was palpable lying along the right side of the vertebral column. Kidneys not palpable. The urine was free from albumen, and its presence never recurred.

The abdomen slowly filled again, and on November 16th the circumference was 25 in. After this it remained stationary and the patient had no discomfort or other bad symptoms. His general condition improved and he was allowed to go home, where he was kept under observation.

Readmission.—He was readmitted in April, 1905, as the tumidity was increasing and his general health was falling. On admission the general condition was much the same as before—circumference of abdomen 26½ in. He was again tapped and 40 oz. of fluid withdrawn with the same characters as before. The abdomen filled more rapidly, and on May 7th 70 oz. of fluid were withdrawn. The fluid on this occasion was examined, and found to contain no less than 750,000 red blood cells per c.mm. Examined chemically it contained 3.75 per cent. of proteid, 0.8 per cent. inorganic salts and a trace of