Menstruation then commenced to be irregular and accompanied by pain, and some months later intramenstrual pain was experienced. This state of things continued for some twelve months, the menstrual periods becoming more irregular and occurring at longer intervals, while the pain became more constant in character. About September, 1909, she noticed her clothing becoming tight, and thought her abdomen was becoming larger. It was not, however, until January, 1910, that she sought medical advice, and was then treated for some weeks apparently on the assumption that she was the subject of tuberculous peritonitis. She had had no previous illnesses of importance, and the family history did not appear noteworthy.

Condition on Examination.

The patient was somewhat emaciated, but did not show any symptoms of respiratory embarrassment, in spite of the enormous enlargement of the abdomen, neither were the functions of the bladder or alimentary canal interfered with to any extent. Inspection of the abdomen showed marked symmetrical enlargement; abdominal respiratory movements were normal. The whole abdomen was very tense, and a well-marked thrill could be elicited. Palpation produced no pain, even on considerable pressure. The whole swelling yielded a dull note, extending as high as the costal margin. Above this there was a resonant area, completely replacing the liver dullness. There was resonance in either flank, and, furthermore, the latter resonant areas could be slightly increased by turning the patient on to the opposite side. Rectal examination showed a normal uterus, freely movable, but an ill-defined mass could be felt lying to the right of this organ.

Operation.

The patient having been prepared overnight, an incision, 5 in. in length, was made through the right rectus muscle near the middle line, extending from the umbilicus to a point about an inch above the pubis. The character of the cyst was at once apparent. Having been found to be free from adhesions, it was tapped, 14 pints of clear, glairy fluid being evacuated; it was withdrawn from the abdomen, its pedicle transfixed and ligatured by interlocking sutures of silk, and removed. The left ovary having been examined and found normal, the abdominal wound was closed by three tiers of sutures.

The anaesthetic used was gas and ether. Recovery was uneventful. The tumour, on examination, was found to consist of one very large and several smaller cysts. No ovarian tissue could be recognized in it by the naked eye.

SPINAL ANALGESIA AND PITUITARY EXTRACT FOR FORCEPS DELIVERY DURING ACUTE PNEUMONIA.

By J. A. HENTON WHITE, M.D., F.R.C.S. EDIN.,
BIRMINGHAM.

I CAN find no record of forceps delivery under spinal analgesia, and venture to think the following case is of interest.

On April 4th I first saw Mrs. M., aged 28. She expected to have been confined of her fifth child on March 30th, and had engaged a midwife to attend her. All went well until April 3rd, when a bad shivering fit, accompanied by stabbing pain in the right chest, set in.

I found her sitting up in bed breathing very rapidly (40), cyanosis was marked, the pulse 140, and the temperature 102°. There were signs of consolidation and pleuritic friction over the lower and middle lobes of the right lung. There was no sign of labour. Next day the patient was weaker and did not recognize people, and showed signs of puerperal insanity.

At 1 a.m. on April 7th I was sent for, and found labour had set in; the os was about the size of a crown, and the waters were broken; the head was above the brim. The patient was desperately ill, the pulse was thready, and the cyanosis was of a livid hue. In spite of strychnine hypodermically, no efficient pains could be induced, and to prevent the patient dying undelivered I decided to try spinal analgesia; 1 c.cm. of a 5 per cent. solution of tropacocaine was injected in the middle line of the back below the twelfth dorsal spine with the patient leaning forwards sitting up in bed. Analgesia supervened rapidly, and I applied forceps with the patient sitting on the side of the bed, with the legs as far apart as possible, and supported on two chairs. I found it impossible to exert enough traction in this position, and put the patient on the left side, with the shoulders well raised on pillows, with the double object of easing the breathing and preventing the fluid running too high up the spine. I then rapidly effected a difficult delivery. The child was a large one, and there was a depressed fracture of the frontal bone owing to the severe traction required and the angle at which I was obliged to pull; it survived only two days. As soon as the child was delivered serious flooding set in, due to atony of the uterus from the spinal analgesia, and also to the engorged state of the venous system. I had anticipated this, and at once injected 12 minims of pituitary extract (Duncan, Flockhart and Co.) into the buttock, and introduced my hand into the uterus; as soon as I had well grasped the placenta a violent contraction of the organ took place, so violent that it

would have been impossible to introduce the hand. The placenta was removed and the bleeding stopped. The pulse greatly improved; instead of being thready and uncountable it became of full volume and good tension, and the general condition was very good.

The pneumonia ran a severe course, the upper lobe of the right lung becoming involved on April 10th, and puerperal insanity set in severely. The patient died from exhaustion on April 19th.

This case, although unfortunate in its termination, is instructive in that it shows the possibilities of spinal analgesia under conditions which precluded the use of a general anaesthetic. The woman felt nothing of the severe traction which I had to use. I could not safely have injected ergot to cause uterine contraction owing to its depressing action on the heart. Pituitary extract acted splendidly in this emergency, and is, I feel sure, a drug to be kept in the midwifery bag for use with a weak heart. Normal sensation returned in the legs about two hours and a half after the injection. The urine had to be drawn off on April 10th.

This case was conducted single handed with the help of an untrained woman, in a badly-lighted room.

SOME OPHTHALMIC CONDITIONS CAUSED OR INFLUENCED BY DISEASES OF THE UPPER RESPIRATORY TRACT.

By A. S. COBBLEDICK, M.D., B.S. LOND.,

LATE RESIDENT MEDICAL OFFICER, GOLDEN SQUARE THROAT HOSPITAL
AND SOUTH LONDON EYE HOSPITAL.

THE consideration of abnormal nasal conditions and the possibility of their presence coincident with eye disease is of much importance to the ophthalmic surgeon in forming his diagnosis and carrying out his treatment; the rhinologist, on the other hand, does not obtain so much assistance from ophthalmology, for nasal conditions are not much affected by ocular disease.

The ophthalmic surgeon may not be able to complete his treatment of a case without the assistance of a rhinologist, but he should be so equipped as to be able to complete his diagnosis without additional advice.

EYE CONDITIONS IN CHILDREN.

Corneal Ulcer.

One of the most common eye diseases of childhood, especially in hospital practice, is ulceration of the cornea. The condition is troublesome to treat, usually very painful, and cure is frequently delayed for years on account of the great tendency to recurrence. As the ulcers may be deep and centrally situated, leaving permanent and dense nebulae, they are the cause of a considerable amount of defective vision.

The chief causative factors are bad hygiene, insufficient and unsuitable food, and the presence of post-nasal growths.

The first and last of these may be said to be always present in hospital patients, but the food factor may not be so prominent, owing partly to the fact that the painful nature of the affection and the general depressed condition of the child makes him refuse the best of food. Bad hygiene, which includes lack of cleanliness, of nursing, of warmth, and of good surroundings, has much to do both with the general ill health and tardy recovery. This is shown in patients admitted into hospital when nearing perforation; the child is cleaned, kept warm, and well nursed, generally as well as locally, he soon begins to eat, and recovery is much more rapid. This, however, is not cure, and recurrence is the rule within six or twelve months; the chief cause of this recurrence is the presence of post-nasal adenoid growth. If the adenoids are removed when the eye condition is quiescent recurrence is the exception. I am so convinced of this that I do not consider any case of severe or even slight corneal ulceration has been adequately treated without resort to this operation, for a slight initial attack may be followed by a severe second one with great disturbance of vision. The following is a typical case:

A boy, aged 6 years, with deep central corneal ulcers of both eyes, much pain and photophobia, was treated for three years at the South London Eye Hospital; on an average he had three recurrences yearly; consequently he was practically in continuous attendance. On three occasions his condition was so