to the ages of the children affected, 18 were 6 or under, and came under the division known as infants. The vision of 7 of the children was less than $\frac{1}{8}$.

The next most common condition was squint. There were 13 cases, and of these 10 were left, 2 right, and 1 alternating. In connexion with this it is interesting to note that the number of cases of anisometropia was 20, and the proportion of worse eyes was 4 right to 16 left. By the term "anisometropia" I mean all cases where one eye differed from the other by one dioptré or more, the worse eye being that with a higher degree of refractive error.

There were 5 cases of nebulae of the cornea. One was due to traumatism, 2 to ophthalmia neonatorum, 1 to phlyctenular keratitis, and 1 of doubtful origin—probably phlyctenular. The other conditions found were: Spasm of accommodation, 2; conjunctivitis, 4; blepharitis, 7; ankyloblepharon, 1; hordeolum externum, 2; heterochromia, 1; congenital cataract, 1; fundus disease, 2 (1 myopic); retrobulbar neuritis, 1; and nystagmus, 1 case (nebulae of cornea).

This year the work has been continued, the total number of children attending the above schools being 1,410. In addition two other schools have come into the scheme—namely:

Linthurst Church of England School with 94 children
Rubery St. Chads " " " 213 "

The total number of defectives treated this year has been as follows:

School.	Boys.	Girls.	Total.
Stourbridge Road	13	9	22
Catshill	—	7	7
Lickey End	1	4	5
Linthurst	2	1	3
Rubery	—	2	2
Totals	16	23	39

The number of visits made has been five. One was a tour of inspection of all the schools to see all the children who had been treated and the way they were progressing. It was extremely gratifying to hear from the teachers how well they were getting on. I may record the case of one of the school "dunces," a child who had given much trouble to the teacher, and who was regarded as a naughty and unmanageable child. A pair of spectacles to rectify the marked refractive error cured the moral and mental deficiencies and rendered the child an industrious pupil! How many children have suffered in like manner in times gone by when a pair of spectacles rather than the "rod" would have rectified matters! The number of glasses prescribed this year has been 39, and of these there were 5 cases of myopia as follows: Myopic astigmatism, 3; myopia, 1; mixed astigmatism, 1.

In addition there were: Squints 8, of which 2 were right, 5 left, and 1 alternating. Other cases were: Spasm of accommodation, 2; nebulae, 1; blepharitis, 1; conjunctivitis, 3; corneal ulcer of strumous variety, 2; fundus disease (tuberculous), 1; and epicanthus, 1.

With regard to the treatment of squint, the best had to be done under the circumstances. Some eyes were hopelessly amblyopic, and others greatly improved with glasses and education by occluding the good eye. The improvement was noticed when the cases were inspected a year later. Except in a few of the younger children, atropine ointment was not given for home use. The majority of the children were over 8. The scheme has worked smoothly, and there has been very little opposition from the parents, who, as a whole, took an intelligent interest in the work and willingly paid for the glasses and treatment. The chairman, Mr. Beesly, usually attended when I went over to do the work, and ably assisted me.

A letter from Mr. Hugh Thompson in the BRITISH MEDICAL JOURNAL of April 16th, 1910, showed that school clinics have been carried on in Woolwich on similar lines. That school clinics can be carried on successfully for

ophthalmic cases I have no doubt, and they have much to recommend them for the country districts.

REFERENCE

¹ Bishop Harman, *Proceedings of the Royal Society of Medicine*, May, 1909.

SUBMUCOUS RESECTION OF THE SEPTUM NASI.

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SUBMUCOUS resection of the septum nasi is an operation of comparatively recent date, but is already in extensive use. Little information is as yet forthcoming as to the after-results. For example, does any regeneration of tissue take place in the septum after removal of the skeletal part? Opportunities of investigating this latter point do not often occur.

On July 2nd, 1910, amongst my other operations at the hospital was a man aged about 38, whom I had not myself previously seen. His complaint was nasal obstruction and "irritation," and the operation proposed was submucous resection of the septum. For this purpose his nose had been anaesthetized with cocaine and adrenalin hydrochloride in the ordinary way. On removing the packing

Fig. 1.

Fig. 2.

Fig. 3.

The thick black lines represent muco-perichondrium or muco-periosteum, the shaded areas bone or cartilage of the septum.

to make a beginning of the operation, I found a deviation of the cartilage to the left and a projection, also to the left, along the line of the ethmo-vomerine suture, preventing a good view of the interior of the nose on that side (see Fig. 1). The usual incision was made, and elevation of the muco-perichondrial flap begun and continued for about $\frac{1}{4}$ in. all along the wound. It was then seen that the cartilage was deficient, as though part of it had been removed at a previous operation, for the elevator was now between two layers of unresisting tissue (see Fig. 2), and also the appearance of the deep surface was not like that of cartilage. The separation was, however, continued as far back as the perpendicular plate of the ethmoid. After this separation, the most projecting part of the cartilage in front and above and the spine below were cut away and the wound closed. It seems clear that a partial resection had been done previously in this case. The patient stated that he had had several intranasal operations, and that after one of them, three years ago, he had worn a rubber splint in each nostril for some time. This latter operation must have been a resection of the septum. In that case

there are two points of interest: (a) the comparative ease with which the muco-perichondrial layers were separated from each other after nearly three years in contact—I came across only a few feeble strands of fibrous tissue crossing between the two flaps; (b) the entire absence of any regenerated cartilage, bone, or fibrous tissue beyond the weak fibrils above mentioned. This case also illustrates the occasional impossibility of making the septum hang truly vertical in the middle line without endangering the integrity of the bridge. When the deviation extends up to the very bridge of the nose it cannot be entirely corrected without removing the entire cartilage. A compromise has, therefore, to be effected, and the final condition is something like that shown in the diagram (see Fig. 3).

THREE BAD PROGNOSTIC SIGNS IN ECLAMPSIA.*

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ON no subject in obstetrics is there more modern literature than eclampsia. From wild guesses at its causation we have narrowed our conception of it down to a toxæmia, though the nature of this toxin, and even its origin, has still to be proved. Research in this direction now belongs to the chemist; for a clinician to attempt to elucidate the problem is mere waste of time, his results being worthless without a long special training. But the clinician can be of service in directing the chemist's efforts, by noting any special train of symptoms or the results from special lines of treatment.

The object of this short paper is to draw attention to three bad prognostic signs in eclampsia—namely: (1) A small amount of albumen in the urine; (2) a high temperature; and (3) *post partum* onset of symptoms—the first two of which I cannot find mentioned in the literature.†

Soon after it became my duty to attend a large number of cases of eclampsia, I was struck with the bad results in patients with these symptoms, and, as time went on, I was more and more convinced that these patients had a much greater mortality than the others. Knowing that our convictions are very often unconsciously formed from isolated cases rather than from the whole, I have now looked up the notes of all the cases of eclampsia admitted to St. Mary's Hospital in the years 1906–7–8, numbering 46 altogether, and find my observations much more strongly confirmed than I could have expected.

I.—Small Amount of Albumen in the Urine during the Eclamptic Stage.

For the purposes of this investigation I have taken 10 grams of albumen per litre of urine as the standard, any amount above that being considered large, anything below small. My reason for choosing this standard is solely that it seems a convenient one and one which gives a good cloud on boiling.

Of these 46 cases, 21 had a slight degree of albuminuria, 18 a large degree, and in 7 cases it was not recorded. The results of these cases were:

- 21 patients with less than 10 grams per litre; 13 died, 8 recovered—mortality 61.9 per cent.
- 18 patients with more than 10 grams per litre; 3 died, 15 recovered—mortality 16.6 per cent.

These figures show an enormous difference in the mortality. Is it not probable that we are dealing with two entirely different classes of cases, though they both have many of the same clinical symptoms?

II.—A High Temperature.

100° F. has been adopted as the standard, and only the readings noted which were taken during the eclamptic stage; a high temperature during the puerperium, after the eclamptic period has passed, being necessarily of other origin.

Of these 46 cases, 26 had a temperature of, or above, 100° F., while 19 did not reach this temperature, and 1 was not recorded, as the patient died immediately after admission. The results of these cases were:

- 26 patients with a temperature of or over 100° F.; 15 died, 11 recovered—mortality 57.7 per cent.
- 19 patients with a temperature below 100° F.; 1 died, 18 recovered—mortality 5.2 per cent.

The results are even more striking than these figures indicate, as several of the 11 recoveries with a temperature of over 100° F., could really be discarded. In two of them the temperature only just reached 100° F. for one reading; in two others there was only a single rise just at the time of delivery; in one the patient had pneumonia and another was septic from a macerated fetus.

The patient who died without the temperature reaching 100° F. was moribund when admitted to the hospital, and died in less than two hours; so it is quite possible her temperature may have been raised before admission.

The temperature of these patients is recorded four-hourly. Several of the fatal cases had only a single rise during the eclamptic stage, but the majority had a progressive rise until death, and this sign warrants the very gravest prognosis. When these two symptoms, a small amount of albumen and a high temperature, occur separately, they are, as shown by these figures, bad prognostic signs; but when they occur together they give the very worst prognosis, while without either the prognosis is extremely good.

Of these 46 cases, 12 combined these two symptoms, while 7 had neither. The results in these cases were:

- 12 cases with less than 10 grams per litre and temperature over 100° F.; 12 died, 0 recovered—mortality 100 per cent.
- 7 cases with more than 10 grams per litre and temperature below 100° F.; 0 died, 7 recovered—mortality 0 per cent.

III.—Convulsions Commencing after Labour.

Very divergent opinions are held of the prognosis in those cases in which convulsions commence only after labour. Recently Johnstone¹ has collected statistics from many of the large clinics, with a varying mortality of 5.2 per cent. to 43 per cent. The author points out that the earlier the onset the milder the attack, and it is quite probable that in many clinics these mild cases are not received, so their mortality is really based on the severe cases. Of these 46 cases, in 8 only did the convulsions commence after labour, and of these only one recovered; in fact, this is the only recovery from this condition in four years at St. Mary's Hospital.

The motive of this short communication has not been an attempt to explain these phenomena, but simply to record them, to see if they are confirmed by the experience of other observers, and, if so, to give some further clinical data to direct the work of the chemical investigator.

REFERENCE.

¹ *Journal of Obstetrics and Gynaecology of the British Empire*, January, 1910.

THE formal opening of the chemical and physiological wing of the University of Bristol by the Pro-chancellor Lord Winterstoke will take place on Tuesday, November 15th, at 3 p.m.

At the half-yearly meeting of the governors of the University College of North Wales, held at Chester on October 26th, it was announced by the treasurer that Sir T. Pritchard Jones had presented the new college with a great hall at the cost of £17,000.

WE understand that the authorities of the Heritage School of Arts and Crafts for Crippled Children at Chailley, Sussex, are finding themselves in difficulties, and require support. The school undertakes to educate both boys and girls, the object being so to train them as to render them capable of supporting themselves by hand crafts. The girls' school is a new building, and both schools have full recognition from the Board of Education; but the boys' school has been carried on in an old house which was only passed by the Board of Education as satisfactory during the experimental stage of the school's work. The authorities of the school are now faced by the necessity of transforming this old house at a cost of about £5,000. The honorary treasurers of the school are Lord Llangattock and Miss Alice Rennie, 36, Westbourne Terrace, Hyde Park.

* Read before the North of England Obstetrical and Gynaecological Society, May, 1910.

† While writing this Galabin and Blacker's *Midwifery* has been published, in which attention is drawn to the bad prognosis with a high temperature.