Previous History.—He had suffered for six years from somewhat similar symptoms.

CASE IV.

A driver in the A.S.C., seen as an out-patient on July 9th, 1915, complained of defective vision, which, however, was due to myopia, as follows: V. = R. $\frac{1}{2}$ c - 3 D. = $\frac{1}{2}$ partly. L. $\frac{1}{2}$ partly c - 2.25 D. = $\frac{1}{2}$ partly. With both eyes $\frac{1}{2}$. At the same time he complained of difficulty as a driver, as he felt unsteady and wished to be transferred to an infantry regiment. There was no sign of nystagmus at time of examination.

Previous History.—He stated that he had always had bad sight, that a few years ago he had suffered from nystagmus, that he was affected by the lights in the pit, and that he found difficulty in staring at lights at the present time. He said that he had been at various times in the army, but had twice been discharged on account of bad sight (probably myopia).

Family History.—Father's sight good; mother's sight weak; eight sisters and one brother have good sight; one brother is said to have suffered in the same way as the patient.

CASE V.

A private in an infantry regiment attended as an out-patient for test of vision on July 14th, 1915. V = R. $\frac{1}{2}$, and L. amblyopic; hypermetropic with some astigmatism; not improved by glasses to any appreciable extent. He complained of pain in the head, and said that he could not bear a strong light.

Previous History.—He stated that he had had weak eyes all his life, that he had had an accident to the head as a child, to which he ascribes the failure of the left eye; that two years ago he had inflammation in both eyes, and that since then he has noticed dancing or flickering lights when working in the mine. He was better after joining the army until he started musketry practice.

CASE VI.

A private in an infantry regiment came up on July 15th, 1915, as an out-patient for examination of eyes.

V. = R. $\frac{1}{2}$ c + 2.5 D. cyl. ax. $\setminus 50^\circ$ = $\frac{1}{2}$ pty.
L. $\frac{1}{2}$ c + 2 D. cyl. ax. | vert. = $\frac{1}{2}$ pty.

Previous History.—He had been troubled with his eyes for twelve months, especially in looking at lights in the pit, and at night when above ground.

CASE VII.

A private in an infantry regiment was seen on July 17th, 1915, on account of failure at musketry practice.

V = R. $\frac{1}{2}$ pty. c - 3 D. cyl. ax. - hor. = $\frac{1}{2}$ c.
L. $\frac{1}{2}$ pty. c + 2 D. cyl. ax. | vert. = $\frac{1}{2}$ c.

There was some slight sign of oscillation of eyeballs, and it was difficult to get him to look upwards.

Previous History.—He stated that he had suffered from miner's nystagmus, which he believed was caused by knocks over the eyes. He complained of the glittering of lights in the dark and of the moving of things before his eyes, especially if reading a paper.

CASE VIII.

A private in an infantry regiment, aged 33, was admitted July 9th, 1915, on account of conjunctivitis.

V. was at first $\frac{1}{2}$ in both, improved in hospital so that on August 18th it was

V. = R. $\frac{1}{2}$ c - 1 D. = $\frac{1}{2}$. L. $\frac{1}{2}$ c - 1 D. = $\frac{1}{2}$.

There was much blinking of eyes and complaint of pains in the temples, and occasional giddiness, causing a fall one evening.

Previous History.—He stated that he had had many knocks on the head, some of which had stunned him. He seems to have had conjunctivitis at the age of 21. For a long time he had been dazzled by lights in the pit, and when he passed a lamp in the street at night time he had to shade his eyes; he said that he often turns dizzy.

CASE IX.

A private in an infantry regiment, seen on July 26th, 1915, said that he had had nystagmus five years previously, when he was off work for six weeks.

V. = R. and L. $\frac{1}{2}$, improved by + glasses with a weak cylinder to $\frac{1}{2}$.

CASE X.

A private in an infantry regiment, seen on August 5th, 1915, stated that he had suffered from miner's nystagmus two years previously, and was obliged to leave the pits. V. = R. $\frac{1}{2}$, not improved by glasses; L., amblyopic. Refraction hypermetropic.

THE fortieth annual report of the Boston Medical Library, presented on January 11th, shows that the war has caused a great falling off in the number of books and journals received. During 1915 seventy-six foreign periodicals had suspended publication, at least for a time, while others had appeared at very infrequent and irregular intervals. The number of volumes added during the year was 3,688, making a total of 89,963 in the library. In 1876, the year after its foundation, it possessed only 4,488 volumes. It is now the fourth in size among the medical libraries of the United States, being exceeded only by the Surgeon-General's Library at Washington, and those of the College of Physicians of Philadelphia and the New York Academy of Medicine.

A METHOD OF TREATMENT FOR
CONJUNCTIVITIS.

BY

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THE treatment of conjunctivitis is an important problem for doctors in the region of the firing line. The ordinary treatment is sometimes ineffective and often slow, with the result that many valuable men in excellent general health are rendered incapable of service for considerable periods owing to the state of their eyes. What is wanted is a treatment which will be at once more effective and more rapid, and it is also necessary that it should be capable of ready application to large numbers of men, and under circumstances in which the facilities for applying even the most simple remedies may perhaps not be very great.

Some of the cases of conjunctivitis are traumatic in origin, others are dependent upon and secondary to some other diseased condition, but most of the cases appear to be simple bacterial infections of the conjunctiva, and so should be susceptible to treatment by ordinary recognized antibacterial methods.

Experience has shown that immunization procedures are peculiarly applicable to many eye inflammations. Gonococcal, tuberculous, and sometimes streptococcal infections of the organ often give most excellent results when treated with the corresponding vaccine. But simple uncomplicated conjunctivitis is apparently seldom due to any of these organisms, and its bacteriology is so inconstant that to apply vaccine therapy would hardly be practicable under war conditions. It is, however, safe to say that any conjunctivitis cases in which styes are present as a complication should certainly be treated with staphylococcus vaccine.

The value of an antiseptic would appear to depend largely, if not altogether, upon the histological position of the invading bacterial army. When the bacteria are superficially disposed, an antiseptic is the most obvious agent by which they may be destroyed. In this process the tissues themselves will suffer injury and death, but such cellular losses will be replaced from the practically illimitable resources of the body, while the superficially placed bacteria have no such reserves to draw upon. When, however, bacteria have penetrated more deeply and have established for themselves in the tissue labyrinth bases where no antiseptic can reach, they can keep up a continuous stream of recruits which, in a war of antiseptic attrition, will be as proof against extermination as the cells of the organ they have invaded. In such a case antiseptics are not only useless but probably harmful, for by devitalizing the tissues they hinder the physiological forces from trying to accomplish the bactericidal effect which the antiseptic itself has no hope of accomplishing.

In conjunctivitis the inflammation is placed about as superficially as it is possible for any inflammation to be. It is the condition above all others in which we might expect an efficient antiseptic to produce good results. Now the substances used for the treatment of conjunctivitis are, as a rule, more distinguished for their astringent than for their antiseptic properties. We thought it would be interesting, and probably profitable, to try the effect of a remedy in which the antiseptic prevailed over any other action, and after some deliberation we chose encol solution as the reagent best suited to carry out the idea, for the following reasons: (1) It is a most powerful antiseptic; (2) it seems strangely non-irritating to the tissues, almost as though it might imitate faintly with regard to bacteria the action of salvarsan with regard to a more developed form of microbe life; (3) it has apparently already given good results in the hands of some reliable workers in the field of general surgery, though, so far as we know, it has not yet been used in infections of the eye.

The investigation was carried out in the following manner:

Acting on advice kindly furnished by Professor Lorrain Smith, we commenced with a solution of eusol ten times more dilute than that used in the treatment of wounds. It speedily appeared, however, that this was too weak and that a solution about five times more dilute than the normal strength used for wounds gave the optimum effect in the treatment of conjunctivitis. Every second case of conjunctivitis was treated by irrigating the conjunctival sac freely three times a day with eusol; the other cases were treated with boric acid and zinc sulphate solution, as being probably the commonest of routine methods.

We took the cases absolutely in the order that they happened to arrive from field ambulances. The only thing that was done in the way of selection was to exclude from the experimental group those cases in which any complications coexisted with the inflammation of the conjunctiva. Cases of blepharitis, corneal ulceration, trichiasis, entropion, and ectropion seemed to us to present incalculable elements the inclusion of which would be likely to lead to ambiguous and uncertain conclusions.

One hundred cases were treated in this comparative manner. Of these 100 cases, the 50 treated with eusol took an aggregate time of 303 days to cure. The cases treated by boric acid and zinc took 448 days before they were fit for duty.

The employment of eusol therefore resulted in the saving of many days in the treatment, the average time required for a cure with eusol being 6.06 days, as against the average time of 8.96 days required to get the same result with boric acid and zinc treatment.

It was further apparent as the result of our work that, apart from any gain in time, eusol might yet be a very useful alternative measure for the treatment of conjunctivitis, for in six cases it succeeded in effecting a rapid cure of the disease where boric acid and zinc had proved unsatisfactory.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

INTUSSUSCEPTION OF THE SMALL INTESTINE DUE TO FIBROMYOMA: EXCISION: RECOVERY.

THE following case appears worthy of record for several reasons. Fibromyoma of the small intestine is rare, especially as the cause of acute following chronic intestinal obstruction in an elderly patient.

A thin lady, aged 50, had been failing in health and having colicky pains and indigestion on and off for six months. She got suddenly very much worse on December 7th, 1915. She vomited frequently, and on December 12th brought up bilious and brown offensive material. Enemata had at first brought away large masses of scybala, but without much relief. The patient had been more or less constipated for years, but she had been much worse of late. Dr. Clowes saw several coils of small intestine across the middle of the abdomen, and felt a hard lump varying in consistency to the left of the umbilicus. He did not think this was faecal, as it persisted after the enemata. His diagnosis was obstruction of the small intestine, probably due to growth. There was no blood in the results of the enemata, but some slime came away with one of them. When I saw her at Colchester, on the evening of December 13th, she looked exhausted and shrunken, but not very ill.

Operation.

Dr. Worts gave the anaesthetic, and Dr. Clowes assisted. A long incision was made through the middle and inner third of the right rectus. I at once felt an intussusception in the small intestine, probably about the middle of the ileum. It was about 8 in. long, and its apex was hard, and thought to consist of a polyp or carcinoma. Very gradually and gently the intussusception was reduced. As the last bit was released a depression was seen on the wall of the bowel, which indicated the attachment of the growth. The latter could now be well felt and moved inside the bowel. It was polypoid, but with a broad attachment, and was 2½ in. long and 1 in. in diameter. The intestine at and just below the growth was grey and thin; therefore I resected about 6 in. of it with the growth, and joined up end to end with two continuous sutures of fine black thread. The intestine above was greatly hypertrophied, and also considerably dilated, probably to twice the natural size. The abdomen was closed in layers with catgut and mass salmon-gut sutures in the usual way. The operation lasted about forty-five minutes. There was no shock at the end. She was given a rectal saline with 30 grains of aspirin immediately afterwards.

A letter from Dr. Clowes, dated January 30th, 1916, stated that the patient had done very well.

A report from the Clinical Research Association stated that "the tumour is composed of bundles of smooth muscle with a very small amount of fibrous stroma. It is not malignant, and has the general structure of a fibromyoma."

Recovery after resection at the end of six days' complete obstruction of the small intestine is uncommon. Resection seemed to be the best treatment, for even if the innocent nature of the tumour had been certain at the time of the operation, excision of the polyp would have involved cutting into the damaged bowel at its mesenteric border. It seemed better to remove the seriously damaged part. The question of drainage of the distended bowel above arose, but in view of the high position of the obstruction this was not thought necessary.

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DUODENAL AND JEJUNAL ULCERS.

SIR J. BLAND-SUTTON says (February 19th, p. 272) that surgery has evolved a new ulcer in the jejunum. He says also that "with an unobstructed pylorus gastro-jejunosomy cannot be relied on to cure a chronic duodenal ulcer . . . as it exposes patients to the discomforts and risks of regurgitant vomiting and jejunal ulcers . . ."

I hold that all ulcers in that region after gastro-jejunosomy are due simply to faulty technique. I fail to see the necessity for pylorotomy in duodenal or pyloric ulcers.

I have shown in my publications in the BRITISH MEDICAL JOURNAL of April 25th and July 25th, 1914, what is, in my opinion, the best operation for duodenal and pyloric ulcers—namely, a posterior gastro-jejunosomy with an entero-anastomosis in every case, done at the same time.

I have had a large experience in this operation, and have had no deaths and no jejunal ulcers occurring afterwards, and no unpleasant symptoms of any kind whatever.

The diagram shows the completed operation referred to.

London.

G. GORE GILLON, Lt. Col. R.A.M.C.

From A to A, 3 in.; B to B, 2 in.; C to C, 1½ in.

PROCIDENTIA UTERI IN A NULLIPARA.

IN the JOURNAL of February 5th, p. 218, in a letter on "Dystocia due to Constricted Os," Dr. W. E. Fothergill of Manchester says that "nulliparous women do not have procidentia uteri (the final or complete stage of prolapsus uteri)." Three years ago I met with a case of complete prolapsus uteri in a woman aged 20, unquestionably a nullipara. The condition had existed for about five months, and was accidentally discovered by her mother, who brought her to me. The vulvar ring had contracted behind the extruded corpus uteri, and an anaesthetic was needed before reduction could be effected. Here there was no overgrowth of the cervix. Cervix and body were both normal in size. It was a case of simple uncomplicated procidentia uteri in a nullipara. She was the daughter of a small farmer, and the condition was attributed by her mother to the carrying of heavy loads of farm produce. A pessary was put in; it was removed a few months afterwards, and, so far as I know, the ailment has not recurred.

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