by a powerful curved toothed forceps. From the inner angle of the eye an incision was carried horizontally outwards towards the malar eminence, and, on dissecting the flap further back towards that point, I was enabled better to estimate the extent of the tumour. With the forceps, I then separated the nasal processes of the superior maxillary from the nasal bone, and carried on the division of the bone horizontally outwards below the infraorbital ridge, being anxious to preserve that portion of the bone. The separation of the maxilla from the malar bone was now effected, and I was then made fully aware of the extensive amount of absorption of bone which had been caused by the tumour. On lifting up the portion of bone separated by the forceps, and passing my finger upwards and backwards, I found the floor of the orbit had been invaded, and the tumour attached mainly to the cranial base, mostly to the body of the sphenoid. Below, it had become attached to the left half arch of the palate, which was removed with the tumour. Externally, the growth extended to a point behind the malar eminence. The extensive attachments of the tumour superiorly, inferiorly, and laterally, made its removal a matter of extreme difficulty. Great hæmorrhage attended the operation, which was checked mainly by the free application of the actual cautery. At first, this failed to arrest it, and I then endeavoured to apply ligatures to the bleeding points; but, owing to the great depth at which they were, this was found impossible. I then applied the actual cautery a second time, and, fortunately, with success. Before closing the wound, I placed a plug deep into it when the bleeding occurred, and then brought the flaps together with numerous points of carbolic catgut sutures, except at the divided portion of the lip, which were approximated with hare-lip pins and a figure-of-eight suture.

The patient's recovery was uninterrupted, immediate union taking place throughout the entire extent of the facial wound. The deformity resulting from the operation was surprisingly little.

Mr. Abraham, the talented Curator of the Museum of the Royal College of Surgeons in Ireland, kindly examined the tumour with his accustomed care; and the note with which he furnished me in reference to its pathology will doubtless be read with much interest.

"The sections of the growth examined are made up of lobules of epithelial tissue, separated by septa of young fibrous tissue, of which the larger sometimes contained newly formed trabeculae of bone. The epithelial cells have large well-defined spherical or oval nuclei, and their cell-substance is more or less granular. In shape, they are occasionally columnar, but more often polygonal, or with an indistinct boundary. They are situated in one or more layers around alveolar spaces, which are generally occupied by a mass of amorphous material. In some parts, the spaces are elongated and parallel, giving the tissue the appearance of a collection of tubular glands."

The points of special clinical interest in this remarkable case were: the exceptionally great size of the tumour; its extensive attachments to the sphenoid, palate, malar, and superior maxillary bones; the alarming hæmorrhage that attended its removal; the rapidity and completeness of the patient's convalescence; and, lastly, the difficulty of arriving at a definite conclusion as regards its pathology. The probabilities of the recurrence of the growth are, I should say, great; but I have not been able to ascertain if there be any evidence of its return as yet.

OCULAR HEADACHE.

By CHARLES HIGGENS, F.R.C.S.Eng.,

Ophthalmic Assistant-Surgeon to Guy's Hospital; Lecturer on Ophthalmology, Guy's Hospital Medical School.

HEADACHE due to irregular or excessive action of the internal or external muscles of the eyeball is familiar enough to ophthalmic surgeons; but in spite of the frequency with which it has been alluded to by writers on ophthalmic subjects, the profession at large does not seem to recognise the connection between pain in the head and abnormality in the eyes.

Perhaps the most common form of "Ocular Headache" is that which occurs in connection with myopia of rather high degree, in which the farthest point of distinct vision is so near the eyes, that very great strain of the internal recti muscles is required to keep the visual lines converged upon the point at which ordinary print or small objects can be clearly seen.

The case reported by Mr. Carter, I think, in the *Lancet*, about four years ago, and so often quoted since as to have become famous, is a remarkable instance of headache occurring in myopia, and de-

pendent on overstrain of healthy internal recti muscles. Other cases dependent on the internal recti occur in emmetropia or slight hypermetropia, but in these the muscles are actually weakened, not overstrained by prolonged convergence to too near a point, in the *Guy's Hospital Reports* for 1875, I called attention to these cases in a short paper on "A Form of Muscular Asthenopia."

The remaining cases of "Ocular Headache" are accounted for by astigmatism—simple myopic of low degree having to answer for many cases—and rather high degrees of hypermetropia. In these, the headache is due to irregular or excessive action of the internal muscles of the eyeball.

Dr. Brailey has called attention to the subject in a paper on "Astigmatism considered in relation to Headache and certain Morbid conditions of the Eye" (*Guy's Hospital Reports*, 1878). The following two cases are good instances of the disease under consideration.

CASE I.—J. K., aged 27, a solicitor, for two months had had difficulty in reading, pain in the head, and general feeling of uneasiness. He had been treated for biliousness, and had taken remedies for headache without relief. He had almost determined to give up business, believing he had some form of brain-disease. He was advised, before deciding, to consult an oculist. I saw him on June 11th, 1880, and found vision and accommodation normal; convergence was good up to one foot, but imperfect nearer; diplopia occurred after exclusion of either eye. There was manifest hypermetropia = $\frac{1}{4}$. I ordered glasses convex 36, decentered inwards, to be used for reading and all near work. On July 7th all the unpleasant symptoms had disappeared. I heard of J. K. some months later. He was at his business, and had no difficulty in reading or writing for any length of time.

CASE II.—Mrs. M. J., aged 39, suffered from headache since childhood; she had used glasses for distance for years. She had always noticed that her headache was worse after reading or working. The glasses she was using were — 14 spherical. I found under atropine myopia $\frac{1}{4}$, with myopic astigmatism $\frac{1}{8}$ in both eyes. Glasses — 18 cylindrical for reading and working, — 18 cylindrical — 24 sph. for seeing at a distance were ordered. Two months later, the headache had greatly diminished, and reading or near work caused no discomfort.

NITRITE OF AMYL IN URÆMIC ASTHMA.

By SOLOMON C. SMITH, M.D.,

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WITHIN the last month, two writers in the *JOURNAL* have testified to the usefulness of nitrite of amyl in allaying the paroxysms of uræmic asthma. There is no doubt about its efficacy; but it is too potent a remedy to be used without great care. Its very power is its danger; for it often gives such relief, even in desperate conditions, that a feeling of false security is apt to be engendered, the gravity of the case being put in the background by the comfortable feeling that relief can always be obtained; and thus, instead of the asthma being accepted as a most urgent warning of danger, the facility of getting relief is taken as a permission to throw aside restraint.

Of this, Dr. Sheen's case (*BRITISH MEDICAL JOURNAL*, April 28th) is a good example. The patient got relief by means of the amyl; then refused further treatment, and died.

Considerable latitude has been allowed in the use of the term asthma, it being often applied to conditions which resemble it in one thing only, that is, in the difficulty of breathing. True asthmatic paroxysms do, however, occur as a result of renal disease, but they form only one species of uræmic dyspnoea. It has seemed to me that, putting on one side cases of pleuritic and pericardial effusion, the attacks of dyspnoea which occur in the course of disease of the kidney may be roughly divided into four groups, in only one of which is nitrite of amyl of much service.

1. True asthma, spasmodic, passing entirely away between the attacks, unaccompanied by signs of cardiac weakness, often produced by errors of diet, and indistinguishable from ordinary spasmodic asthma, except for the discovery between the paroxysms of symptoms of chronic kidney-disease.

2. Exceedingly rapid breathing, with sensations of breathlessness, but without any obstruction to the respiration, without wheezing, and without apparent effort. This, in a minor degree, is one of the ordinary early symptoms of kidney-disease, but is sometimes so aggravated as to seem to stand out by itself as a disease apart. Neither of these conditions has appeared to me to be at all markedly under the control of nitrite of amyl.

3. Cardiac dyspnoea, due to the failure of the heart; a sign that regeneration of the cardiac muscle is taking place, and that hypertrophy is no longer truly compensatory, an urgent warning that the mode of life must be altered, so as to bring the demands upon the heart within its lessened power. The attack generally occurs in the night. There are orthopnoea, a sense of suffocation, and a feeling of being in danger of death, unless something can be moved from the chest; the hands are cold and clammy; the face bathed in perspiration; the heart's action is laboured and irregular, but the arteries are almost pulseless; the muscles of deep respiration act forcibly, and air freely enters the lungs; but this gives no relief to the miserable sense of apnoea, which goes on sometimes for several hours, until, towards morning, a little frothy expectoration occurs, often tinged with blood, and the breathing gradually becomes less difficult. At this time, patches of fine mucous rales can be heard in the lungs, which persist for perhaps twenty-four or thirty-six hours, during which period the breathing remains somewhat hurried, but after then the patient often appears fairly well. When these paroxysms occur at comparatively long intervals, they generally seem to be brought on by cold, or fatigue, or indigestion, and are usually regarded as asthmatic; but sometimes they are repeated so frequently, that the patient is never quite free, and then they become what is in fact a mode of death. In either case, it is most essential that their meaning should be recognised as pointing to the heart.

These are the cases in which nitrite of amyl most distinctly shows its power. During its inhalation, the pulse fills out; the limbs become warm; the breathing is relieved; and the misery passes away; but it is most important that the rapidity with which ease is obtained should not be taken as proving the neurotic origin of the attack. The case is not one of asthma, but of failing heart; hypertrophy has done what it can; and is no longer able to overcome spasm of the arterioles; the patient has come to the end of his tether, and now must be content to draw in. An isolated attack of this form of uræmic dyspnoea sometimes gives a warning far ahead, and makes it possible to adopt in good time such a course of treatment as enables life to be prolonged often for a very considerable period—a broken life, no doubt, and one lived out upon a lower platform, but still better than the alternative. If, on the other hand, the warning be neglected, and the treatment be limited to the use of such doses of amyl or nitroglycerine as suffice to keep down the attacks, the quantity of the drug required rapidly increases, and it is soon found no longer to produce the desired effect.

The true place of nitrite of amyl in these cases is not as a treatment in itself, but as a means of giving quick relief to the distressing symptom. When this has been done, then a course of treatment for the disease must be arranged. This should generally include a life free from worry and excitement; careful protection from cold; the use of such baths and frictions as are found to keep the skin in good order; sufficient daily exercise to ensure good digestion; a diet regulated according to the digestive power, and the requirements of the body; the use of aperients, especially when bad weather prevents exercise; the steady employment of small doses of iron and digitalis, interrupted as may be found necessary for the treatment of those catarrhs and indigestions which are the chief breaks in the monotonous progress of these cases; and then, if from some exposure to cold, or mental excitement, or error of diet, attacks of dyspnoea should recur, nitrite of amyl will again be of use as before, as a means of getting relief from the urgent distress.

4. Bronchitis, congestion of the lungs, and pulmonary apoplexy, give rise to great difficulty of breathing, which sometimes comes on so suddenly as to look like an asthmatic attack; but there are generally ample physical signs to distinguish it from other forms of dyspnoea. Although these conditions are often associated with dilatation of the heart, the block is too organic to leave much room for the action of nitrite of amyl.

Of the four groups, then, into which cases of uræmic dyspnoea may be arranged, in one only is nitrite of amyl of much service. In that class, however, its beneficial action is most striking, and it stands almost alone in the rapidity with which it gives relief to the breathing. It must, however, be used with both caution and intelligence; otherwise, instead of giving an opportunity for useful treatment, it may only mask the progress of the disease, and while easing painful symptoms, merely lead the patient on to euthanasia.

THE Local Government Board have, on the application of the Wokingham Local Board and Urban Sanitary Authority, declared Section 90 of the Public Health Act, empowering the making of by-laws as to houses let in lodgings, to be in force within the said district.

OBSTETRIC MEMORANDA.

A CASE OF MONSTROSITY.

I WAS called to attend Mrs. E. in her fourth confinement, on May 9th, 1883. On my arrival I found the water had come away about twenty minutes before, and projecting from the os externum was a fleshy mass so unlike any usual presenting part of the fœtus to the touch, I was quite at a loss what to make of it. However, another pain coming on solved the riddle at once, the feet and leg or legs being expelled; and in a short time the shoulders and head followed. The child was alive, and continued so for eight hours. The mother made a good recovery. I send a rough sketch of the

child, which was the only thing the parents would allow. From the head downwards to about midway between the sternum and the umbilicus it was in every respect well formed, and to outward appearance perfectly natural. From about that point the following particulars were noticed. There were no projections at the usual site of the crests of the ilia. The abdominal cavity was small, and seemed to be almost destitute of contents. The genito-urinary organs were represented by a small round aperture surrounded by a slightly elevated fleshy ridge (represented by the lower dot in the figure). The limbs were enclosed in one continuous fold of integument, although the bones could be felt quite separate underneath; and in front there was a slight depression marking where the division ought to have been between the limbs. There was no separation of the buttocks; in fact, there was very little of the usual projections at this point, and there was no anal orifice. The feet were joined together at the heel and partially so at the centre of the foot, but the toes were well formed, in the usual number, and free. I would have liked a *post mortem* examination, but the parents objected. The mother said she had only gone eight months. There was no history of a fall or fright, except a bad dream about the fourth month.

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ALBUMINURIC RETINITIS OF PREGNANCY.

Mrs. E., aged 22, was referred to me by Dr. Temple on June 1st, 1881, with the statement that the urine contained a large amount of albumen. The patient stated that her sight had been failing for about a month. She said she could see the sides of an object, but not the centre; and complained of flashes of light in the dark. She had frontal headache, sometimes severely. She had no pain in the eyes. There was a great deal of nausea and vomiting. She was in the fourth month of her first pregnancy. With the right eye, she saw fingers at five feet, and read 16 Jäger; with the left, she saw fingers at three feet, and read 20 Jäger. With the ophthalmoscope, I observed, in the right eye, a well marked stellate arrangement of deposits about the yellow spot, with numerous patches scattered about the retina. The optic disc was somewhat swollen and indistinct in its outline. The appearances in the left eye were very similar, with the addition of numerous small hemorrhages in the lower half of the fundus.