semi-gangrenous diverticulum and the damaged loop of ileum. I am strengthened in this belief by the extreme restlessness and delirium which occurred after the operation. Of course the long continuance of the symptoms of strangulation and the shock of operation also contributed materially to that end.

Whether a resection of the loop of gut would have given a more favourable result must remain an unsolved problem. It would undoubtedly have added much to the shock of the operation, but this might have been more than counterbalanced by the removal of an important source of the supply of septic material to the system.

Dr. KEEN (Philadelphia) congratulated Dr. Atherton on his bravery and his honesty in reporting a case in which an error was made. Only thus by the experience of a colleague could the rest of them learn to avoid similar errors. In this case the circumstances made the error quite explicable if not excusable. Only those among them without sin should cast the first stone.

Dr. SHEPHERD agreed that the overlooking of the hernia of the ileum through an opening in the mesentery was quite excusable, and still more so when operating in the country with poor assistance and the light of a lamp held by a novice. Even in a hospital such a condition might be overlooked. He had assisted the late Professor Fenwick in a case of obstruction where a gall stone was found in the diverticulum; the patient made a good recovery. The speaker said Meckel's diverticulum occurred in almost 3 per cent. of individuals, and was of various shapes. The speaker had several times seen a dilated end which was bifid, and this was seen frequently in the pig. In such a diverticulum faecal matter could be easily retained and dilatation would occur.

HYPERPHORIA AND OCULAR HEADACHES.

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ONE of the factors in some ocular headaches and neuralgias which it is important to bear in mind is the existence of a latent deviation, more especially in the vertical direction, upwards or downwards, and constituting what is known as hyperphoria. This condition can be rendered evident by means of a Maddox's disc (consisting of five or six pieces of a red glass rod, each about an inch long, and of the thickness of a lead pencil such as is attached to ball programmes; these pieces are fixed side by side on a circular brass disc. A point of light regarded through them appears lengthened out into a red line at right angles to the axis of the rods). This disc is placed in the spectacle trial frame before the right eye, and in such a position that the glass rods lie vertically; the glasses which correct the patient's ametropia are also placed in the frame before each eye. The flame of a candle, situated 6 metres off, in a darkened room, is now looked at, and the patient says whether the horizontal red streak of light is on a level with the centre of the candle flame or lies in a different plane. If the latter, a square prism is held before the Maddox's disc, with its apex vertically upwards or downwards according as the streak is below or above the candle flame; that prism which makes the red streak appear to pass through the centre of the flame is the measure of the hyperphoria. The test for hyperphoria can also be carried out without Maddox's disc by a modification of Snellen's red and green test, as described in Lang's *Examination of the Eye*.

Slight degrees of hyperphoria, represented by a prism of 0.5 D. or less, are not uncommon, and can exist without occasioning symptoms of discomfort, but now and then it calls for correction, as in the following case.

Mrs. P., a lady of middle age, was seen by me in April, 1895. She then complained of severe frontal headaches, and of a constant tired feeling and aching in the eyes, and of her inability to read or sew for more than a few minutes at a time. This had been the case for years, and glasses (-3 D. sp.) had given but slight relief; medicinal treatment had also been without much effect. On testing her vision she

read $\frac{5}{6}$ with $\frac{-6 \text{ sp.}}{-1.5 \text{ cy. } 30^\circ \text{ in.}}$ before the right eye, and $\frac{5}{6}$ with $\frac{-4 \text{ sp.}}{-2 \text{ cy. } 30^\circ \text{ in.}}$ before the left.

Retinoscopy under 2 per cent. homatropine and cocaine gave

R.	-6.5	L.	-6
	-5		-4.5

and she now read R. $\frac{-5 \text{ sp.}}{-1.5 \text{ cy. } 30^\circ \text{ in.}} = \frac{5}{6}$; L. $\frac{-4.5 \text{ sp.}}{-1.5 \text{ cy. } 30^\circ \text{ in.}} = \frac{5}{6}$.

On recovery from the drops the same results were obtained. On now testing the balance of the ocular muscles I found there was exophoria to the extent of a prism of 1.5° d., and hyperphoria, which was corrected by a prism of 0.75° d. apex down before the right eye. The base line was 58 mm. There were no myopic crescents, but in each lens there was a circle of fine peripheral cortical opacities, such as is frequently met with in myopic eyes. In ordering the glasses for the distant vision I gave the full ametropic correction, and disregarded the heterophoria; for reading I gave weaker glasses—namely:

R. $\frac{-2 \text{ sp.}}{-1.5 \text{ cy.}}$ L. $\frac{-1.5 \text{ sp.}}{-1.5 \text{ cy.}}$ combined with the prismatic cor-

rection of the hyperphoria—namely, a 0.375° d. prism, apex down, in the case of the right eye, and a 0.375° d. prism, apex up, in the case of the left.

On the 22nd of the next month the patient returned saying that while the reading glasses were quite comfortable, she had been unable to wear the distance ones after the first day or two, so I put the correcting glasses into the trial frame, together with the vertical prisms. These the patient kept on with comfort for a quarter of an hour, and I concluded that the prisms were as necessary in the distance glasses as in the reading. They were ordered accordingly, and were worn with complete relief, as the patient testified three weeks later. In fact there has been no further eye trouble since.

I have no doubt that many other ophthalmic surgeons have had similar cases, but as there is but scanty reference to them in ophthalmic literature it is only right that their occurrence should be emphasised, and general attention be drawn to the striking relief which the use of vertical prisms can bring about in some cases where the most exact correction of astigmatism or other error of refraction is without avail.

I may add that when hyperphoria is associated with eso- or exo-phoria, the latter may usually be disregarded; though in some cases a prism has to be found and to be set in an intermediate axis before equilibrium is produced. Such a resultant prism can be arrived at by calculation (Maddox), but the best results are perhaps obtained by rotating prisms in the trial frame, and selecting that one which in a certain axis seems most comfortable.

THE STATE MEDICAL SERVICE AT ST. PAUL'S.—That the State medical service held last year at St. Paul's Cathedral was highly appreciated by the profession is shown by the fact that upwards of 1,100 practitioners attended, more than 500 of whom wore academical robes. It is therefore not surprising to learn that the Guild of St. Luke has decided to repeat it this year on October 19th, at 7.30 P.M., when the Archbishop of York has consented to preach the sermon. Unfortunately it has been found necessary on account of the large attendance to limit the number of tickets issued to those who are not members of the medical profession. A very influential Committee, comprising many of the leaders of the profession, has been formed. Invitations will be issued to all practitioners residing in London, and all attending, if University graduates, are requested to wear the hood and gown of their degree, whether in Medicine, Science, or Arts. Invitations will not be sent to practitioners resident in the country, but all who wish to attend can obtain tickets on application to either of the Honorary Secretaries: S. Russell Wells, M.D., M.R.C.P., 24, Somersset Street, Portman Square, W.; C. Devereux Marshall, F.R.C.S., 10, Devonshire Street, Portland Place, W.