Conclusions.

1. One application of radium to the uterine cavity is sufficient to complete the menopause. Hence operative procedures are unnecessary purely for this purpose.
2. The method is not free from distressing or even dangerous results.
3. Just as in oophorectomy and panhysterectomy so also in all methods which suddenly induce the menopause ovarian extract should be given as a routine proceeding.
4. Many illnesses at the time of the menopause may be due, either wholly or in part, to ovarian insufficiency, and in all such illnesses ovarian extract should be given a trial.
5. Asthma may be due to a deficiency in one of the internal secretions, and this may possibly account for the success of adrenaline in certain cases, of pituitrin in others, and of ovarian extract in this case.
6. In asthma two factors may be at fault and both must be treated to obtain a satisfactory result.

Note by SIR HUMPHRY ROLLESTON.

Dr. MacBean Ross's account of this remarkable case is so clear that little remains, except, perhaps, unfruitful speculation as to the relation between the administration of the ovamammoid compound and the cessation of the grave asthmatic state.

That the beneficial effect of this preparation was solely due to suggestion seems improbable, because other forms of treatment just as likely to produce such an influence had proved futile. As the ova-mammoid preparation was given by the mouth and not hypodermically it can hardly be argued that it acted, like the intramuscular or intravenous injection of peptone (Auld), as a non-specific desensitizer. Lastly, it is difficult in the present state of our knowledge to say that the sudden production of ovarian insufficiency caused, by means of the resulting upset of the endocrine balance, a metabolic asthma; it is just conceivable that from sudden withdrawal of an ovarian internal secretion the thyroid secretion might become relatively excessive and so render the central nervous system susceptible to stimulation by the "foreign" protein provided by the antral suppuration, with the result that asthmatic manifestations followed.

Such speculation, though attractive to the speculator, is not based on the proper basis of experiment, but it renders all the more desirable investigation of cases of asthma occurring after the artificial production of the menopause.

A NOTE ON THE TREATMENT OF SQUINT.

BY

HENRY SMITH, C.I.E., LIEUT.-COLONEL I.M.S.,

LONDON.

UNDER the term "squint" I include all non-paralytic errors of muscle balance of the eye. There has been a large amount of interesting work done on the anatomy of the extrinsic muscles of the eye, and on operative procedures to correct errors of muscle balance. I recently attended discussions on these issues in the United States of America. The only comment I made during these discussions was that we would do well to shake ourselves free from all that had been done and revert to first principles.

From the mechanical point of view it seems to me that nature has inserted the extrinsic muscles of the eye in such a position that each shall obtain the same maximum leverage and that this leverage shall be constant whatever the position of the eye. That is to say, the recti muscles are inserted well in front of the equator, the equator or any point in front of it being equally the position of maximum mechanical advantage. Hence the retarding of any tendon would be mechanically unsound. From the physiological point of view it is well known that the force with which a muscle contracts increases with the degree to which it is stretched within limits before contraction. Tendon tucking or advancement stretches one of the muscles of the eye and introduces a factor which cannot be gauged.

From the surgical point of view any cutting operation leaves scar tissue which is subsequently liable to contract, and none is more likely to do so than tendon tucking. The latter almost invariably means muscle tucking, hence it can be seen that no operative procedure can pretend to anything like scientific accuracy. In fact, in almost all cases the final result is practically cosmetic.

C

I wish to draw attention to the case of an Indian banker who came to me at Amritsar in 1917. He had had an ordinary seventh-nerve paralysis, from which he had recovered a few months previously. The muscle balance of his mouth had gone wrong and was a disfigurement—permanent, as is usual in such cases. I gave him an electro-magnetic apparatus and showed him how to use it. After a couple of months he came back to me with the mouth pulled to the opposite side—that is to say, towards the nerve originally paralysed. The last I saw of him was two years afterwards. The shortening he had produced had remained permanent.

The muscle balance of the eye is exactly analogous to the muscle balance of the mouth. If we can alter the Indian banker's mouth permanently by a course of electrical stimulation of the muscle on one side, we can similarly alter the muscle balance of the eye. There is no means of getting away from this issue.

While on a holiday with a friend recently in a village in Nova Scotia, a girl of 10 years of age was brought to me; she had $7\frac{1}{2}$ degrees of external squint. I had no dark room nor apparatus with me. A local doctor kindly lent me an electro-magnetic apparatus. I spent a few sittings with the child, allowing her to play with the instrument so as to gain her confidence. I used an ordinary sewing needle as one pole, placing the other pole on the nape of the neck. With the eye cocaineized I pushed the needle through the conjunctiva not more than one-eighth of an inch towards the affected muscle. She could not stand the hum of the instrument, so my friend did the make and break of the current with his hand. I gave her about fifty shocks of such strength as the child would put up with over the internal rectus of one eye in the morning, and over the internal rectus of the other eye in the evening. At the end of five days—ten sittings—the squint, as examined in open daylight, was reduced to 2 degrees.

I had then of necessity to leave this very interesting case, and the best I could do was to order her a pair of 1 D prisms. At this stage I secured a piece of red glass, and found that with it she had $7\frac{1}{2}$ D, and without it had 2 D, showing that she was exercising $5\frac{1}{2}$ fusion power.

It was noticeable in this child that the little shock produced caused the child to vomit occasionally after the sitting, and this tendency naturally limited the length of the sitting and the strength of the current used. This is not surprising, as in children or adults any shock associated with surgical interference with the eye often causes a vomiting of this kind. The right technique for this procedure has yet to be settled.

I would suggest that the patient should be put under gas for the minute or two required at each sitting, the eye being also cocaineized, a meridional slit made in the conjunctiva about one-eighth of an inch over the muscle, the pole insulated with sealing-wax to near the point, and the muscle submitted to a fairly strong current in this way twice a week.

If this is done I have no doubt the operator will get what shortening he requires with very few sittings; that he will be able to adjust the length of any extrinsic muscle of the eye to the physiological length; and that he will run no risk of mutilation. To emphasize the main issue of the procedure I advocate: If one can rapidly by means of a series of electric shocks shorten permanently and to any degree required the muscles which balance the mouth, by analogy you can similarly shorten permanently any of the extrinsic muscles which balance the eye. The procedure which I advocate would do away with all operations for muscle balance and with the use of prisms for this purpose.

PULSATILLA IN DYSMENORRHOEA.

BY

FREDERIC C. COLEY, M.D.,

PHYSICIAN TO THE NORTHERN COUNTIES HOSPITAL FOR DISEASES OF THE CHEST; CONSULTING PHYSICIAN TO THE HOSPITAL FOR CHILDREN, NEWCASTLE-UPON-TYNE.

THIRTY-ONE years ago a patient came to me suffering, amongst other things, from dysmenorrhoea. It was very severe, causing nausea and prostration, and the pain sometimes reduced her to helplessness. She was then over 30, and had suffered in this way since her third period, at the beginning of which she had "taken cold." I prescribed, by a fortunate inspiration, pulsatilla, a remedy which I had previously been led to regard as useless. The result was such that the patient afterwards told me that the fee she paid me was the best investment she had ever made in her life. Since then I must have used pulsatilla in hundreds of cases. In many it has been entirely successful. In most it has given great relief. I believe those in which it has completely failed have been few.

The cases in which I prescribe pulsatilla give a history of this kind: They have pain for the first day or two of each

catamenial period. Sometimes it begins a day or so before the period. The loss is usually small. I have not been accustomed to use it where the amount is excessive, lasting six days or more, and attended with passage of clots, pain continuing through the whole of the period, or nearly so. Most of the patients that I have treated have been unmarried. Married women having this type of dysmenorrhoea are apt to be sterile.

I do not pretend to know the precise pathology of these cases. I never make a vaginal examination in them, which is mischievous where it is not necessary. I am quite satisfied with the knowledge that in the great majority of patients giving the history above detailed pulsatilla affords wonderful relief. When I prescribe it I usually give the following explanation: "You may get great and immediate relief at the first trial of the medicine. That often happens. But do not be disappointed if it does not. If you get any relief at all at first, you may expect with great confidence that the benefit when you use it at the next period will be much greater. Probably when it has been used at five or six periods the pain will be entirely abolished, after which the medicine may be given up with very little fear of a relapse. But if that should occur at any time, the medicine may be resumed with good effect." The cases in which these prophecies have been unfulfilled have been in my experience very few. How pulsatilla relieves dysmenorrhoea I do not know. I have never known it to produce any undesirable effect, or indeed any other effect at all than that for which it was prescribed. It is certainly not a narcotic. The formula I use is:

R Tr pulsatilla 3iv
Spt. chlorof. 3ij
Aq. chlorof. ad 3vj

Two teaspoonfuls of this to be taken as soon as menstrual (or pre-menstrual) pain begins, and every three hours while pain continues.

It cannot be supposed that the minute quantity of chloroform contained in 3ij of this mixture materially aids the pulsatilla. But it is most efficient as a preservative, so that I tell the patient that if the bottleful is not finished when pain ceases the rest of it may be kept for use at the next period.

It may be objected that suggestion is largely concerned in the success of this treatment. Absolutely to disprove this would be difficult. But the remarkable uniformity of the results makes it exceedingly improbable. To me it is a question of merely academic interest. What I care for is that severe pain, often producing serious disability, is relieved, and in many cases entirely abolished, by a remedy which is quite harmless and in no way disagreeable. And these are advantages which certainly cannot be claimed for the stem pessaries which were in vogue in my younger days, or the operations for dilatation of the cervix which I have seen described in recent works.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

OBSTRUCTION OF THE PELVIC COLON BY THE PEDICLE OF AN OVARIAN CYST.

The notes of the following case, in which the obstruction was caused in a remarkable manner, seem to merit publication.

On August 28th, 1921 I was called by a local Muslim doctor to see his mother-in-law, a lady of 55, who was obviously suffering from symptoms indicating an obstruction of the bowel, incomplete in character. On the previous day she had had a sudden attack of moderately severe pain in the lower abdomen, followed by vomiting (once). An enema given in the evening had resulted in the passage of a little faeces and flatus, but did not relieve the pain. When I saw her, her abdomen was slightly distended, particularly over the caecal and sigmoid areas; tenderness was not marked, and there was no rigidity. The pulse rate was 80, the temperature normal. She gave no history of genito-urinary trouble.

Castor oil was ordered, but was returned, and an enema with turpentine produced a small motion without passage of flatus. On the following day her condition was much the same, and she was removed to hospital for further observation, and in case the necessity for operation should arise. A further enema resulted in the passage of considerable flatus. During this and the following day her condition was chiefly remarkable for the variation in the severity of the local symptoms. Pulse and temperature remained unelevated. The spasms of pain varied in their intensity and duration, and frequent enemata only occasionally produced flatus. Abdominal distension was, on the whole, less marked. A small stool was passed on the 30th after an enema. On the 31st the pulse rose to 96 and the temperature to 99°F., and her general condition was obviously worse. She complained bitterly of the increase of pain after the enemata. I advised a laparotomy, but

first insisted on making a vaginal examination. This revealed an ill-defined lump on the right side. The fundus uteri could not be felt.

On opening the abdomen under spinal anaesthesia (stovaine) by a subumbilical incision, the omentum was seen passing down to become attached to a right-sided ovarian cyst about the size of a cricket ball. The uterus was displaced to the left and the pelvic colon was found to be ensnared by the cyst pedicle in a most remarkable manner. The pedicle, under considerable tension, about the thickness of the index finger, and showing several twists, passed from the uterus posterior to the obstructed loop, then over the latter from behind forwards, and finally to the left and posterior to its proximal portion, emerging under cover of this to reach the base of the cyst. The cyst was lying horizontally, with its apex to the right and pointing downwards slightly. The loop of colon was moderately distended, and showed a fairly pronounced ring at the point of constriction.

After ligaturing and dividing the partially adherent omentum, the obstruction was first relieved by division of the pedicle between ligatures at the point where it appeared from behind the loop and the cyst removed. The remaining (proximal) portion of pedicle was then ligatured and removed from its uterine attachment. The broad ligament on the side of the cyst was extremely rudimentary. The abdomen was closed in layers without drainage. Apart from a rise of temperature on the third and fourth days due to malaria, which promptly yielded to intramuscular injections of quinine, the patient made an uneventful recovery.

The cyst was incised after removal and proved to be a dermoid containing a large quantity of hair in about 12 ounces of viscid dark yellow fluid. The total length of the pedicle was about 8 inches; it was dark red in colour, due to extravasation of blood, and it presented an unusual feature in that its diameter was uniform throughout.

How the cyst and its pedicle came to establish the relations found at operation it is almost impossible to guess, but it seems reasonable to suppose that the omentum was to a large extent responsible for their maintenance. The adhesions were recent, and probably followed the twisting of the pedicle. This being abnormally long must, I think, be regarded as the primary factor in the causation of the obstruction, and no doubt the weight of the cyst, aided by gravity, prevented the bowel escaping from the noose.

I wish to thank the Director of Health Services in Iraq for permission to publish these notes.

G. S. WOODMAN, M.B., B.S. Dunelm., F.R.C.S. Edin.

Mosul.

ERUPTION RESEMBLING VARICELLA IN LOBAR PNEUMONIA.

As there has recently been correspondence relating to the possible identity of the virus of herpes with that of varicella it may be opportune to place on record a case of lobar pneumonia accompanied by herpes labialis, and, on the approach of crisis, also by an eruption clinically identical with or resembling very closely that of varicella.

A young man, aged 24, was admitted to the Midday Mission Hospital at Bethnal Green on August 1st, 1921, suffering from acute lobar pneumonia. There was a good deal of herpes around the nose and mouth. He stated that after feeling unwell for a few days he was taken suddenly ill three days before admission with pain in the chest and vomiting. He was found to have dullness at the base of the right lung, and a well marked patch of consolidation extending from the second to the sixth costal cartilage and three to four finger-widths from the right sternal border. Diminution of resonance extended considerably below this, but cleared up without further sign of effusion.

On August 4th there was an outbreak of red spots, quite irregularly distributed, on the upper part of the chest. These took five or six days to clear up, but only a very few of them showed vesicles. On August 6th there was an extensive vesicular outbreak on the back, covering the whole of it in an irregular manner and showing no tendency to group along the nerve tracks. The larger of these became pustular and terminated by scabbing. Umbilicated vesicles were not observed.

The whole eruption was not simultaneous in development, and it lasted many days; but I regret to say that the date of the termination of scabbing is not marked in my notes.

London, W.

WM. SALISBURY SHARPE, M.D., M.R.C.P.

THE OPERATION OF CHOLECYSTGASTROSTOMY.

To your issue of November 19th, 1921, Mr. C. A. Moore, of Bristol, contributed an interesting case of pancreatic tumour, and added a valuable review of the literature of cholecyst-gastrostomy. His remark that "cases in the literature since 1914 are naturally scarce" prompts me to add the following case of malignant disease of the pancreas to the list.

A railwayman, aged 45, was admitted to hospital in August, 1920, suffering from chronic obstructive jaundice of several months' duration. He complained of intermittent pain in the upper abdomen, and intolerable itching from jaundice, which was deep and progressive. In the preceding six months he had lost 14 lb. There was slight uniform distension of the abdomen, and a distended gall