Comments on the Operation.

1. By raising the bridge of the nose an epicanthus can be eliminated.

2. Scarring of the skin of the nose from previous trauma or disease interferes considerably with the cosmetic result of the operation just described.

3. In many cases the defect is too deep to be filled by a single cartilage graft—as, for example, in those instances in which a patient can see one eyeball with the other eye. Here the operation is duplicated. The right fourth cartilage is used for the first operation, and at the second operation, which is done only after an interval of one year or longer, the left fourth rib cartilage is used to complete the filling of the defect.

4. Cartilage, especially when wet with normal saline, is a slippery substance to hold, and unless he is well on guard against such an accident the surgeon may find the graft slip out of his fingers and come to rest upon some unintended and infected landing place.

5. In one instance the cartilage graft shifted after the operation had been completed.

This was in a case of a very large defect, and during the first operation it occurred to me that I might be able to remedy to some extent the forward prospect of the nostrils by making the cartilage graft somewhat longer than the plasticine model, so that when inserted it would thrust downward the lower end of the nose. There was such a deep ledge for the graft to rest against at the upper end of the defect that I thought dislocation was impossible. However, the graft did gradually become displaced, the upper end slipping forward and upward.

Had this displacement taken place laterally, or had the case been one where a single graft only was needed, the accident would have been most unfortunate. As it is, however, probably no irregularity will be noticeable when the second stage has been completed. In any case, I do not now think it was sound practice to attempt an elongation of the nose by inserting a graft large enough to cause considerable pressure and counter-pressure.

INJURY TO THE BOWEL WITH RECURRENT HAEMORRHAGE.

BY

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THE following case is recorded as one of interest on account of the long history and intermittent character of the symptoms, of which haemorrhage was a prominent feature. It has been suggested that the recurrent haemorrhage was due to the formation of an aneurysm in a vessel at the site of injury in the bowel, which appears to be the most probable explanation of the case.

Pensioner J. B., aged 33, was admitted to hospital on January 13th, 1922. In 1917, while serving in the trenches during shelling, he was struck in the abdomen by a sandbag blown in from the parapet. He was seized with abdominal pain, shortly followed by the passage of dark-coloured blood from the rectum in considerable quantity. He was admitted to hospital, and after a couple of weeks, the pains having subsided and no further haemorrhage occurring, was transferred to England. While in hospital there he had two more severe haemorrhages from the bowel accompanied with pain, and the question of operation was considered. This was eventually negatived, and he was discharged some time later. Since then haemorrhage, similar in character but slight in amount, generally followed the taking of solid or more particularly of indigestible food. The haemorrhage was always accompanied with pain. He voluntarily restricted himself to a diet mainly of slops, and from being a professional footballer had refrained from exercise.

On examination tenderness was present in the left side of the abdomen, to which area the pain was referred. Nothing else was detected. Rectal examination was negative. In the course of preparation for a laparotomy which was decided on the administration of an enema was followed by a good deal of pain and the passage of a quantity of dark-coloured blood.

The abdomen was opened to the left of the middle line and the gut was systematically examined. Two small areas of scarring, without deformity, were present in the lower part of the ileum. In the lower part of the jejunum a circular area of bluish discoloration of the size of a farthing and resembling a haematoma was present on the antimesenteric surface of the gut; extending from this, to the root of the mesentery, was a cord-like deposit of lymph. On palpating the gut a definite area of thickening corresponding to the discoloration was felt. The remainder of the bowel appeared normal, as did the other viscera. The portion of gut containing the lesion was resected and the continuity of the bowel restored by anastomosis. He made an uneventful recovery and was discharged from hospital on February 23rd, 1922. He has since returned to ordinary diet, and there has been no recurrence

of the pain or haemorrhage; he expresses himself as being quite well.

The specimen removed, on section, presented the appearance of a haematoma, dark clotted blood occupying the space between the mucous membrane and outer wall of the bowel. The muscular coats were torn, blood being extravasated throughout, and in direct contact with the mucous membrane, which appeared intact.

My thanks are due to Surgeon Captain Bishop, R.N., C.M.G., administrator of this hospital, for permission to record the case.

Memoranda:

MEDICAL, SURGICAL, OBSTETRICAL.

A CROSS-WIRE AXIS FINDER IN ASTIGMATISM.

THE following description of a very simple piece of apparatus may be of interest to those who are engaged in refraction work, for it saves a great deal of time, tends to efficiency, and is so small that it can be carried in the ophthalmoscope case. It consists of a ring, the exact size of the trial lens mount, across the middle of which stretch two fine wires at right angles to one another.

In retinoscopy, if a band of light is seen, or if one appears in the course of correction, this cross is placed in the front cell of the trial frame in such a position that one of the wires is exactly parallel to the edge of the band. This wire is in the axis of astigmatism, and where its extremity appears to meet the scale will give the reading required. The wire is very easily seen as a fine black line against the illumination of the fundus.

There are now four ways of checking the finding:

1. Move your own head slightly sideways, so that the wire is up and down the middle of the band. If now the black line appears parallel to the edges, and does not approach them at an angle either at the top or at the bottom, the axis is indicated correctly.

2. Move your light along the second wire, and if the band keeps at right angles to this and follows the same direction, not sneaking off above or below, the axis is correct.

3. Overcorrect considerably, and the band will appear turned into the other meridian, and should then have the second wire exactly up and down its length.

4. Put a cylinder into the frame, with its axis over the meridian of the wire. If the wire is right there will not appear to be any rotation of the band now; if the wire is wrong the band will appear to be rotated through quite a perceptible amount, this rotation depending partly on the amount of error and partly on the strength of the cylinder used. This is a delicate check, as the error is magnified, so that, say, five degrees of error will send the band round through ten or fifteen.

My instrument was made by removing the brass rim from a trial-box lens and forming the cross of the fine wire used by florists, but it is difficult to get the wires exactly at right angles and to have the crossing point exactly in the centre. I have used it for the last twelve months, doing difficult refractions at an average rate of sixty a week, and find that in nine cases out of ten it gives the cycloplegic correction straight away. The failure in the tenth case is due to fatigue in the observer and is not instrumental in origin. Messrs. Dixey, 3, New Bond Street, will make the apparatus for anyone who requires it.

Southampton.

JOSHUA KEYMS, M.D.

THE THIRD STAGE OF LABOUR.

Is anyone prepared to give an authoritative statement why in some cases pressure on the fundus uteri readily delivers the detached placenta and in other cases pressure sufficient to hurt the patient has no effect? The other day I attended a multipara and the second stage made me think I would have an easy time with the after-birth. In twenty minutes, with the easy confidence engendered by the second stage, I pressed on the fundus and there was no satisfactory opening of the vulva that indicates a speedy end. Having ample time I decided to be patient, but after several unsuccessful attempts, including traction on the cord (*Clinical Obstetrics, Jardine*), I found ninety minutes had passed since the child was born, so I proceeded to remove the placenta manually. As I expected, I found it lying in the upper strait of the vagina. It seemed to me that synchronously with my looking