tenay, in an article on Colour Blindness in Denmark, published in Knapp's *Archives of Ophthalmology* in 1881, says that he examined the eyes separately in 217 cases, and that the two were always alike. I do not recall any later observations of this nature at the present moment. Fontenay mentions that Niemetschek had reported four congenital monocular cases, but stated that he himself regarded them as doubtful. My little patient belongs to a family in which the other members are quick sighted and endowed with acute hearing. They have not yet been tested for the presence of monocular colour defects.¹

Some years ago I drew attention² to the importance of recognising the possibility of the colour perception not being alike in each eye. The following case was mentioned:—

CASE II. *Dissimilar Defects in Colour Vision in the Same Person.*—The patient, a youth aged 21, had, about twenty months before he was first seen, fallen from one of the large Liverpool docks and sustained serious injuries—fracture of the frontal bone, of the inferior maxilla, of the right femur, and of the left wrist. He was stated also to have suffered from concussion of the brain, and quite recently had been the subject of "fits." At the time of his coming to me there was a large depression on the left side of the forehead. He mentioned vision as having become worse since the accident, but I have no note as to its condition when first seen. Later it is stated there was H.+5D. in each eye, and that corrected V. in the right was $\frac{3}{4}$, and in the left $\frac{2}{3}$. Ophthalmoscopically there was nothing abnormal. The point of particular interest was the condition of his colour vision. When about to test him he told me that he was less accurate with colours since his accident. He hesitated rather, and was slow in arranging Holmgren's wools, but he did so correctly. Each eye was then tested separately. With the right he sorted the wools as a red-blind person would do, whilst with the left he did so more as a green-blind person, but less distinctly so. Thus he appeared red blind with the right eye and incompletely green blind with the left. Tested again with both eyes open the correct sorting of the colours was repeated. It seemed as if the faulty sense in one eye was counterbalanced by that which was good in the other. The tests were repeated several times, and left no doubt upon my mind as to their correctness. Unfortunately the patient disappeared shortly after, and I have not been able to trace him to see if his condition has undergone change.

Examination of each eye separately means double labour, and in testing large numbers this is a matter of consequence. It is hardly likely that a difference between the two eyes occurs very often, as is indeed shown by Fontenay's statistics referred to above. Some large numbers dealing with this point would however be interesting. As in the case of my little patient such a condition is overlooked, unless an accidental circumstance or testing reveals it.

CASES OF JAUNDICE DUE TO ANEURYSM OF THE HEPATIC ARTERY AND TO MOVABLE KIDNEY.

By W. HALE WHITE, M.D.,
Physician to Guy's Hospital.

THE two following cases are so very rare that they seem worthy of record. In the first, jaundice was due to the pressure of an aneurysm of the hepatic artery on the hepatic duct. Von Schueppel³ alludes to eight cases and Caton⁴ to the one he records and ten others. The symptoms appear to be pain, a tumour which may be pulsatile, and jaundice. In my case the pain was not great, and was naturally thought to be due to the empyema. The left lobe of the liver was a little prominent, but that was regarded as evidence of pus pushing the liver down, and, as an aneurysm was quite unsuspected, we were at a loss to explain the jaundice. In most of the recorded cases the aneurysm burst, causing sudden death; generally, as in my case, the rupture took place into the peritoneal cavity; in the other cases rupture into the biliary passages occurred. In Borchers's case,⁵ as in mine, there were two aneurysms, and his patient was a male, aged 17 years, and my patient was a male, aged 18, and in both the aneurysms were about the size of Tangerine oranges. The cases were, therefore, curiously similar. The points of difference were that in Borchers's case both aneurysms were in the substance of the liver, but only one in mine, and in his case rupture took place into the hepatic duct. I cannot make out whether in his case both were on the same

branch of the hepatic artery; in mine one was on the left and one on the right. I cannot at all explain the cause of the aneurysms; they did not appear to be infective.

In my second case, as the patient is still alive, it is impossible to prove, and even after death it might be impossible to show, that the attacks of jaundice, and bile in the urine were due to the pressure from time to time of the movable right kidney. All that can be said is that during the time that the patient had a movable kidney he was liable to these attacks, in which the urine became quite dark, and that after the kidney was stitched into position he was never noticed to be jaundiced, he never observed his urine to be dark, and when it was examined it never contained bile. Litten⁶ records a case of jaundice, in which, as in my case, the attacks came and went suddenly, without any symptoms of catarrh or gallstones. Here, also, there was a movable kidney on the right, side to which he attributed the jaundice. No operation was performed in his case.

Landau⁷ remarks that jaundice is more common in women with movable right kidney than in others, but he is inclined to attribute this to the fact that the movable kidney in some way or another renders them more liable to duodenal catarrh. It is difficult to see why this should be so, and it is quite impossible to prove it. My patient did not have any of the sickness, *malaise*, and depression so common with what is called catarrhal jaundice. The renal impression on the liver is so near the transverse fissure that the kidney need not move far to press on the bile duct. I do not know that the kidney has been stitched for jaundice previously to my case, in which Mr. Arbuthnot Lane operated.

CASE I. *Jaundice due to an Aneurysm of the Right Branch of the Hepatic Artery, together with an Aneurysm on the Left Branch.*—A young man, aged 18, was admitted into Guy's a few hours after the initial rigor for right-sided pneumonia. The attack terminated by lysis. The temperature fell gradually during the eighth, ninth, tenth, and eleventh days. On the last of these it reached normal. On the fourteenth day a hectic temperature began, and this continued till his death. There was some pain in the right side. A localised empyema was found on the twenty-fourth day under the right nipple. As the hectic continued, an attempt was made with an exploring needle to find another collection of pus in the front of the chest, but none could be found; so it was determined to try a day or two later to find pus in the back part of the chest, but before this could be done, the patient died suddenly. From the position of the localised collection discovered at the necropsy, there is little doubt but that it would have been found during life. On about the twentieth day slight jaundice was first noticed, together with bile in the urine. The jaundice gradually deepened, the urine became very dark, and the stools pale. There was a fulness over the left lobe of the liver. On the thirty-fourth day of the disease the patient was sitting up in bed, and he suddenly fell back, became unconscious, and died in about ten minutes.

Necropsy.—Except for a small compressed part at the base, the right lung was quite healthy; the pleura was adherent. There was a localised collection of pus between the lung, the ribs, and the vertebrae, lying close against the spine. The omentum and intestines were oedematous; there was a considerable amount of blood-stained fluid in the abdomen, and a large blood clot occupying the pelvis and the lateral regions of the abdomen. An aneurysm the size and shape of a Tangerine orange was found on the right branch of the hepatic artery. It lay in the transverse fissure of the liver, and pressed upon the hepatic duct, and to a slight extent on the portal vein. Its walls were very thin, and at its lower part the wall had given way. It was filled with *ante-mortem* clot, which showed no softening. A similar but smaller aneurysm also filled with *ante-mortem* clot sprang from the left hepatic artery about an inch after that vessel had entered the liver, which was compressed around it. This aneurysm had not burst; it was not visible from the outside of the liver.

CASE II. *Floating Kidney probably causing Jaundice.*—R. K., aged 34, admitted into Guy's Hospital, December 17th, 1890. His previous and family history are unimportant. On March 4th, 1891, he was struck in the back by a falling pile of straw hats, which knocked him forwards; after this trembling in the limbs came on, followed by weakness, especially of the right arm and leg, pain in the back, and great "nervousness." He frequently attended Guy's and Charing Cross Hospitals for these symptoms, but no diagnosis was made, nor could I come to any conclusion as to their cause when he was under my care.

January 1st, 1891. His urine, which had previously been quite clear, and which he had never before noticed to be dark, had been, he stated, for the last twenty-four hours, quite dark. This was found to be true, and it was deeply bile-stained; the conjunctivæ and skin were slightly jaundiced. A rounded body could be felt below the liver on the right side; it was very movable; pressure on it gave testicular pain; and there was little doubt that it was a movable kidney. The patient had very little of the depression of spirits common in catarrhal jaundice. The morning urine contained much less bile than an afternoon specimen.

January 2nd. Morning urine contains a slight amount of bile; afternoon none; jaundice almost gone. January 3rd. Urine normal, no jaundice. January 4th. Morning urine contained a little bile, afternoon urine a good deal; no jaundice. January 5th. A little bile in the urine. January 6th. Morning urine contained a trace of bile, midday none. January 7th. No bile. January 8th. Morning urine no bile, afternoon specimen a faint trace. January 9th, 10th, 11th. Urine contains a little bile, no jaundice. January 12th, 13th, 14th, 15th, 16th. Urine contains no

¹ Mrs. D. has since informed that she has tested them herself with wools and not detected any defect.

² *Lancet*, 1881, vol. i, p. 727.

³ Von Ziemssen's *Cyclopaedia*, vol. ix, p. 835.

⁴ *Clin. Soc. Trans.*, vol. xix.

⁵ *Aneurysma d. Art. hepaticae*, Kiel, 1878. I have not seen the original.

⁶ *Charité-Annalen*, p. 193, 1878.

⁷ *Movable Kidney in Women*, *Syd. Soc. Trans.*

bile. January 17th. Urine contains bile. January 18th to 23rd. Urine contains no bile. January 24th. Urine contains bile. January 25th. Urine free from bile.

On many occasions during the month of January the right kidney could be felt to be movable. On January 28th Mr. Arbuthnot Lane saw the patient, and it was decided that the right kidney should be cut down upon. This was done on February 6th, and it was found to be freely movable. Mr. Lane stitched it into its normal position. The patient remained in the hospital till the end of April, but at no period was the urine observed to contain any bile, and he said that he never once passed any dark urine, nor was he ever jaundiced.

MEMORANDA:

MEDICAL, SURGICAL, OBSTETRICAL, THERAPEUTICAL, PATHOLOGICAL, ETC.

ON THE USE OF OXYGEN IN SEVERE BRONCHITIS.

Mrs. —, aged 56, whose illness commenced with an attack of influenza, followed by acute bronchitis, which, in the course of a week, brought her into a sinking condition, was seen at 7 P.M. on the seventh day. She was completely insensible, with great cyanosis of face, lividity of finger nails, irregular respirations, a very small compressible pulse—in fact, she was *in extremis*, and a consultation was suggested, and Dr. Lauder Brunton kindly came down to see her. I had previously given her an injection of ether, which improved the pulse a little. At Dr. Brunton's suggestion a hypodermic injection of strychnine was given in both arms, and two cylinders of oxygen procured for inhalation, which was given by means of a glass tube in the mouth; but very little hope was entertained of her recovery.

I saw her again in two hours' time, when the cyanosis had disappeared, but she was still quite insensible. In three hours' time she became conscious, asked where she was, recognised her son, and, in fact, made jocular remarks to a lady friend, and very much objected to having a glass tube in her mouth. An emetic of 30 grains of carbonate of ammonium was then given, which she had no difficulty in swallowing, but which, unfortunately, had no effect, as she did not seem to have sufficient strength to vomit. The patient lived through the night; on seeing her the following morning she had relapsed to her former condition. Some more strychnine was injected, and oxygen again inhaled, and her friends told me she again became conscious, sufficiently so to talk. I was called to see her again at 2.30, but found her dead. The supply of oxygen had run out. I took a fresh cylinder with me, but it was too late.

I think the chief interest in this case is in raising the question of possible recovery, when *in articulo mortis* from asphyxia, from accumulation of secretion in the bronchial tubes, as in this woman's case. I think if she had had sufficient strength to vomit after the emetic, and so cleared the air passages, she might possibly have recovered; but to watch the effect of the inhalation was simply marvellous; the woman seemed to come literally out of the jaws of death to life, although only to a very artificial life. Again, the question of temporary consciousness for signing a will or any legal document is of interest. The oxygen was obtained from the Oxygen Gas Works in Horseferry Road.

Westminster.

T. A. O. LANGSTON, M.R.C.S.

GOUT OF THE PENIS.

HAVING been much interested in the perusal of a case of gout in the penis, recorded by the President of the Clinical Society of London, January 8th, 1892, I am induced to forward a somewhat similar one, which occurred in my practice nearly thirty years since.

The patient was a captain in the Royal Navy, married, and near 60 years of age, and—singular to mention—I was called upon the following summer to attend him for a second attack, the penis then being the principal part that was mostly affected. It was greatly swollen, with priapism, there being so small an orifice for the escape of urine (phimosis) that I had to slit up the prepuce. The organ was enveloped in lint, kept constantly wet with a sedative lotion; it was very tense, and frightfully painful. The testes were unaffected. There

was much ardor urinæ; at that time he did not complain of any particular uneasiness about any of the joints. Potas. bicarb. c. colchico et magnes. sulph. were given in frequent doses, so that the bowels were freely relieved. The diet consisted chiefly of milk gruel. The attack of urethritis was followed by a copious discharge of muco-purulent matter. Upon the fifth day of the attack the priapism yielded, after which pains of a slight and transient character were manifested. The patient had had occasional attacks of gout in the right foot.

At the time I considered the case somewhat unique, not having met with a similar one during twenty years' work. Rheumatism I have often witnessed attacking the testes, ending in urethritis. I regarded the case as one of gout attacking the penis, owing to the highly acid condition of the urine. No doubt having to relieve the phimosis at an early stage of the disease by operation contributed to a very great degree to the brevity of the attack, with the alkaline treatment then carried out.

Bournemouth.

SPENCER SMYTH, M.D., F.R.C.S.

REPORTS

ON

MEDICAL & SURGICAL PRACTICE IN THE HOSPITALS AND ASYLUMS OF GREAT BRITAIN, IRELAND, AND THE COLONIES.

WESTERN GENERAL DISPENSARY, LONDON.

A CASE OF EPIDEMIC DERMATITIS.

(Under the care of EDWARD TURNER, M.R.C.S., L.R.C.P., Resident Medical Officer.)

AFTER reading the paper by Dr. Savill on the Epidemic of Dermatitis noticed in the Paddington Infirmary,¹ I was at once struck by the resemblance of the symptoms described to those in the case of a woman I have lately had under treatment, and whose condition I have briefly described below. I think there can be no doubt that the patient was suffering from the same disease as that described by Dr. Savill. The patient lives in Lisson Grove, which is in the western district, outside of which district no similar cases have, I believe, up to now been recorded. I have seen no other case resembling this one amongst the patients attending this dispensary, and I could not discover any clue which would point to the disease being caused by contagion. During the course of her illness, neither the patient's husband nor any of her children suffered from any form of skin disease.

Two striking points in the case were, first, the great prostration caused by the disease; secondly, the ineffectual result of treatment, which consisted mainly of alkalies internally with sedative lotions and ointments to the affected skin. The patient was too ill to come to the dispensary; she was, therefore, visited at her home, which consisted of two very dirty rooms in a basement. The case is of interest from the fact that it proves that the epidemic was not confined solely to the local infirmaries, but that it also occurred in their neighbourhood.

Mrs. S., aged 40, has a family of seven children; the youngest was born in May, 1891. Her illness commenced at the end of June, 1891.

On August 26th, 1891, she came complaining of a rash accompanied by intolerable itching, sore eyes, debility, and loss of appetite. She was a fairly-developed and well-nourished woman. Her complexion was dark, and the face was rather puffy. The eyes watered freely; the conjunctivæ were swollen and inflamed, especially the palpebral portion, which had a dark crimson velvety appearance on eversion of the lids. The skin of the eyelids was rough and scaly. The forearms were covered with a fine scaly rash, the skin being somewhat brownly pigmented, surface rasping to the touch. The lower extremities, especially the legs, were in a very similar condition to that of the arms, but the rash was less marked and not so diffuse. The lungs and heart presented no abnormality.

September 1st. Face more puffy, moderate œdema of feet and ankles. Urine contains no albumen.

¹ BRITISH MEDICAL JOURNAL, December 5th, 1891.