likely that opinions may vary as to the conclusions to be derived from it; and I for one am quite prepared to admit that, so far as it has gone, by itself it is not large enough to base any absolute conclusion upon. But the opinion which I have formed from it—which is substantiated by more recent investigation not yet mature enough for publication, and which has made an increasingly strong impression on my own mind—is that, if a patient is suffering sufficiently to justify abdominal section for chronic inflammatory disease of the uterine appendages, and only one side is found to be affected, the operation, to be of that lasting and complete benefit to the patient which we desire all our operations should be, must be made bilateral. On such a point as this, of course, the desire of the patient must be paramount, as upon most others; and, if a patient places herself under my care for such an operation, and makes it an imperative condition that I should not under any circumstances remove the second set of appendages if they were found healthy, I should yield to her decision; but I should argue the question with her, and advise her not to subject herself to the risks of a second operation, as seems to be by far the greater tendency in unilateral operations. The list that I now present puts such incomplete operations in a very unsatisfactory light.

ENTIRE FREEDOM FROM PAIN AND UNDUE REACTION AFTER EVISCERATION AND INTRODUCTION OF THE GLASS VITREOUS.

By P. H. MULES, M.D.,

Surgeon to the Manchester Royal Eye Hospital.

I AM unwilling to delay in making generally known a means of relief from pain and undue reaction after eviscerating the contents of the globe. I am certainly indebted to Mr. Lang for a hint, the correct interpretation whereof remains with me, for, whilst I drained the globe without benefit in my early cases, he drained the subsceral space by removal of the whole sclera, and to that attributed his success. Severe pain has always followed evisceration, which the introduction of the glass sphere in nowise diminishes or increases.

The pain is due to a rapid pouring out of serum into the subsceral space, with subsequent infiltration and tension of the orbit; it is a pressure, not an inflammatory pain. To avoid this, after completing all the steps of the operation as hitherto conducted, cut the external canthus, burrow freely back into the orbit with a pair of sharp scissors to the back of the sclera, taking special care to open the subsceral space; introduce an antiseptically horsehair drain, the cut ends just passing through the cut canthus; apply a dry, thin, absorbent pad, and an ice-bag over all.

There has not been the slightest pain or undue reaction in the two cases I have just completed, and I submit these suggestions with a feeling of hope that we have overcome the only contra-indication of the operation.

SURGICAL MEMORANDA.

SUB-PERIOSTEAL EXCISION OF SHOULDER-JOINT.

ON September 14th, 1885, W. C. applied to me; his shoulder-joint was swollen, hot and painful; its mobility was much curtailed, the movements being limited to abduction in common motion with the scapula, and a slight power of advancing and retracting the elbow. The ankylosis was almost complete; there was very great nocturnal pain, and over the insertion of the coraco-brachialis was a sinus of some age, still discharging; this led, through a distance of five or six inches, to the inner side of the shoulder-joint.

He was placed under the influence of iodide of potassium, and rested for three weeks, when, the nocturnal pain still remaining great, I resolved to remove the head and neck of the humerus.

On October 28th, with the assistance of Mr. Watson and Drs. Connan and Vise, I proceeded to perform Ollier's sub-periosteal operation, with proper antiseptic precautions, under the carbolic spray, the skin-incision reaching from the outer side of the coracoid process to the insertion of the pectoralis major, the latter not being cut; the periosteum was then incised along the inner edge of the bicipital groove, and the tendon turned out with a retractor. The usual rotations in and out enabled me, by means of the raspatory, to separate the thickened periosteum with great facility; the head of the bone was then pushed out of the wound, and the saw applied just below the great tuberosity; two inches and a quarter of bone were then removed. The inner side of the periosteal pouch thus made was seen

to be covered with nodules of new bone. The glenoid surface was healthy.

A drainage-tube was conducted down the sinus over the insertion of the brachialis anticus, from the wound. Some iodoform was placed in the gap, which was carefully closed; healing took place in about ten days; passive motion was commenced about the fourteenth day. The head and neck of the bone were covered by pits and depressions, soaked in pus, and deeper in the cancellous substance were many loose sequestra.

On March 25th, 1887, there was no tenderness; abduction could be effected nearly to the shoulder-line; he could place the forearm behind his back, and could advance the arm well to the front; was beginning to recover the power of rotation; had great purchase in lifting from the ground, and was doing a good day's work. A new joint apparently existed between the coracoid and acromion processes.

Tunbridge Wells.

CLELAND LAMMIMAN, F.R.C.S.

LATE RICKETS.

THE following case may be of interest as bearing on Mr. Clutton's paper on Late Rickets in the *St. Thomas's Hospital Reports* for 1886.

K. P., aged 25, consulted me in 1883 for extreme genu valgum, the inner malleoli being sixteen inches apart when the knees were close together and the thighs parallel. She also suffered much pain in her knees, which often gave way under her suddenly, throwing her to the ground with much violence. The previous history is of much interest, for up to 14 or 15 she was as well formed as the rest of her family, but at that time her health failed, she became weak and listless, her wrists and ankles became enlarged, and her knees distorted. She had cod-liver oil and tonics given her, but was told that nothing could be done for the deformity. When she consulted me she was quite strong in health, but most anxious to be relieved from her pain and crippled condition. On August 23rd, 1883, I did a double McEwen's operation for her, with the result of making her three inches taller, and enabling her to get about actively and well—in fact, as well as her sisters.

The evidence of rickets in this case rested chiefly on the swollen condition of the epiphyses of the wrist and ankle; but, if I had seen Mr. Clutton's paper before, I might have found other evidence.

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CLINICAL MEMORANDA.

HYPODERMIC INJECTIONS OF CUCAINE IN FACIAL NEURALGIA.

COLONEL G., an old and well-known campaigner in South Africa, has for the last eight years suffered most acutely at varying intervals from this disease. During the attacks, which lasted from a few days to three weeks, the spasms occurred nearly every ten minutes. The right side was the one affected, and while the attack lasted, merely touching the moustache was sufficient to bring on acute spasm. This was so marked in some of the attacks that taking food became an almost unbearable process.

During the eight years in different parts of the country, and at different hands, every variety of treatment had been adopted, even to the extraction of all the teeth in the right half of the upper jaw. Morphine, even in large doses, never gave more than very temporary relief, a very strong current from a battery being, in the patient's experience, the only remedy of the least value, and this at best but a slight one.

In November, 1886, during an attack which had already lasted a fortnight, I saw the patient for the first time, and he then sent for me to request me to divide the nerve. This operation, however, according to most writers, is not attended with very satisfactory or permanent results, and I persuaded him to allow me to try the effect of cucaine before proceeding to this last resource. One-sixth of a grain injected into the cheek hypodermically gave on the first day relief for several hours. For three successive days after this one-third of a grain gave relief only for an hour or so. After this I injected half a grain night and morning with the most completely satisfactory results. After three days at this rate I gradually diminished the dose, and the pain ceased entirely.

Since this occasion, during the last six months, two attacks have begun, but have in both cases been stopped at once by the injection of cucaine in half-grain doses.

During the intervals of attack no cucaine is ever used, but, armed with a hypodermic syringe and a few of Burroughs and Wellcome's