usually grouped as examples of retro-bulbar neuritis. In such cases there may often be observed facts other than the above, which suggest that the pathological lesion is situated in the trunk of the optic nerve. Thus the pupil light response on the affected side is either lost or is seriously defective; often, whilst there is a sharp contraction at the outset, this is only momentary, and almost at once gives place to full dilatation. Again, there is frequently pain on lateral movement of the eyeball, as if this strained some part in a condition of undue irritation. And, once more, it is not infrequent in such cases to observe that whilst at the outset the optic disc has a perfectly normal appearance, later on the whole or part of the disc becomes unduly white, just as if a lesion in the nerve behind the globe had led to a degenerative or sclerotic change which, travelling along the nerve fibres, had ultimately reached the optic disc itself. Thus, whilst blindness in both eyes developing without appreciable ophthalmoscopic change means the presence of some poison in the blood, a one-eyed blindness with similar attendants means a lesion in the post-bulbar portion of the optic nerve on the affected side. The nature of such a lesion, it must be admitted, is somewhat obscure. The suddenness with which the blindness in these cases usually develops suggests at once that the lesion is vascular in origin, and the pain on movement of the eyeball already referred to may be quoted in proof of its inflammatory nature. Certain it is that the phrase retro-bulbar neuritis is advanced as the appropriate diagnostic title. Even if the accuracy of this be allowed, however, an explanation of such an occurrence is very difficult. In some of these cases there has been exposure to a cold wind shortly before the onset of the blindness, and thus it has been suggested that the condition is parallel to a Bell's paralysis occurring in like circumstances. In other instances, however, no such history has existed. Syphilis is another explanation which has been advanced, but it certainly does not apply to the majority of the cases. One of the most interesting associations of retro-bulbar neuritis is disseminated sclerosis. It is quite beyond dispute that in a certain proportion of cases a retro-bulbar neuritis has been followed by the development of this disease. The interval between the two may be a long one, but the cases in which the sequence has been observed are too numerous to be dismissed as mere coincidences. Granting the view that a retro-bulbar neuritis depends on a vascular lesion, its occasional association with disseminated sclerosis has a further interest, when it is remembered that the modern view of this disease is that it depends on patches of inflammation in the cerebro-spinal axis produced by an infective agent present in the blood. What determines the locality of these patches is quite uncertain, but it is notorious that their distribution often departs widely from a pattern of bilateral symmetry. Hence the almost invariably unilateral development of retro-bulbar neuritis does not necessarily remove it from a clinical and pathological relationship to disseminated sclerosis. And its usually sudden development is obviously in harmony with the inflammatory and vascular theory of that disease. But to all this it is necessary to add the remark that not every case of retro-bulbar neuritis develops at a later stage into disseminated sclerosis. It is a clinical event which,

more especially in the case of a young adult, brings the nervous system under suspicion, but beyond this it is not safe to advance. In a fair proportion of the cases the eyesight is regained in perfect measure; in others there is more or less permanent damage; whilst in a third group the eye remains practically blind. But, whatever be the immediate result, it is certain that many patients who have suffered an attack of retro-bulbar neuritis continue to enjoy good health for many years after the event. Their nervous systems do not show any evidences of disseminated sclerosis or of other form of organic disease. Thus the prognosis, both immediate and remote, in any case of retro-bulbar neuritis is one of much difficulty. If recovery from the loss of sight is to take place, signs in this direction can usually be appreciated within a fortnight or less, and so long as these are absent the prospect is uncertain. With the individual patient it would seem unnecessary to mention the possibility of disseminated sclerosis in the entire absence of all other suggestions of that disease. Rest for the eyes, potassium iodide or iodide of iron, and perhaps blisters to the temple, comprise the main measures of treatment and often gain a striking success. Yet it must be allowed that retro-bulbar neuritis remains somewhat of a mystery, and, though amaurosis as a cloak for ignorance has, thanks to the ophthalmoscope, a much diminished opportunity, there yet remain cases of blindness which present a riddle hard to be read.

THE TREATMENT OF RECTAL PROLAPSE BY THE SUBMUCOUS INJECTION OF PARAFFIN.

THE operation of injecting hard paraffin into the tissues to remedy slight deformities is now a well established practice. But the method hitherto has been chiefly used in the treatment of slight facial defects, such, for example, as sunken nose. Possibly the hesitation to make more frequent use of paraffin injections in other conditions has its origin in the one or two disastrous cases that have been recorded, such, for example, as Pfannenstiel's,¹ where pulmonary embolism occurred after the injection of 30 c.c. of paraffin for the cure of prolapse of the bladder. But it would appear, in the light of experience, that such accidents should be regarded as the results of imperfections in the technique and materials used rather than as dangers inseparable from the operation; and from the successes more recently recorded it seems likely that the scope of the procedure will be considerably extended. Mr. Arthur Burgess² reports the results of 18 cases in which he used paraffin injections to cure prolapse of the rectum, the patients' ages being from three to 48 years. The paraffin used melted at 111° F. The method he adopts is as follows: First, a syringe with rubber-covered barrel is warmed in a water bath at 120° F., then filled with sterilised paraffin at the same temperature and allowed to wait in the hot bath. The patient is anaesthetised and placed in the lithotomy position, the prolapse drawn down and its apex gently stretched into a triangular shape by three artery forceps attached to equidistant portions of the mucous membrane. The needle of the syringe is inserted, in turn, into the middle of the folds forming the sides of this triangle, and two or three

c.c. of paraffin are introduced on each occasion. When this has become firm, the stiffened portion is pushed up and another lower part of the prolapse similarly treated, but the angles of this triangle are made to correspond with the lines of the preceding one. As a rule three such tiers are necessary. To prevent the paraffin entering a vein: (1) a blunt needle must be used, (2) the point must move easily in the submucous tissue, and (3) the fold of membrane should be raised with the forceps to form a good ridge. In the 18 cases, all severe, Mr. Burgess has had no case of recurrence of the prolapse. The advantages of this method over others, such as linear cauterisation, excision of folds of mucous membrane or of the prolapse, and colopexy, are its simplicity, the absence of risk to life, and the shortness of the after-treatment. The benefit is apparent immediately the paraffin has set, there is a greater probability of permanent cure, and even should this method fail, the patient's condition is no worse than before, and the procedure may be repeated.

¹ Stephen Paget, Brit. Med. Jour., 1903, p. 11. ² Lancet, Sept. 10, 1904.

ARGYROL IN ULCERATIVE COLITIS; THE VOMITING OF ENEMATA.

IN recording a case of ulcerative colitis Dr. W. Murrell¹ draws attention to the good effect following the injection of a solution of argyrol into the bowel. The regulation of the diet and the use of lead acetate and other astringents, had been practised without avail before argyrol was tried. The plan adopted was as follows:—The patient was first given an enema of boric acid, 8 grains to the pint, and then, by an irrigation tube of small diameter a 1 per cent. aqueous solution of argyrol at 80° was used. About 5 pints were introduced, the patient being in the knee and elbow position. The frequency of the motions promptly diminished, and the temperature rapidly fell to normal. As a matter of precaution the treatment was repeated on two subsequent occasions. But there was no return of the diarrhoea, and in the course of a few days meat, potatoes, and green vegetables could be taken with impunity; the patient began to gain weight, and ultimately he made an excellent recovery.

A fact of much interest was noted in the case—namely, that during the rectal administration of the argyrol solution a claret-coloured fluid identical in appearance with that injected escaped from the mouth, and that, too, without retching or vomiting. This, it was at first suggested, was altered blood or bile, but when analysed by Dr. Wilson Hake was proved to contain silver, and not to differ materially from the 1 per cent. argyrol solution. There was not the slightest reason for believing that such an unusual condition as the existence of a short circuit between the rectum and the stomach existed, and Dr. Murrell regards the event as fairly comparable to the vomiting of enemata by hysterical and other patients. Of such instances he quotes a considerable number recorded in medical literature. Among these is a case reported by Sennest, in which a girl of 12 years vomited a large suppository after introduction into the rectum “dans le temps de réciter un *Pater noster* et un *Ave Maria*.” A second suppository attached to a thread, and a third “secured by four strong ligatures” were treated in the same fashion.

There have been numerous examples of the vomiting

of enemata. In one case, recorded by Dr. Parkes Weber,² when an enema of oil was given the oil reappeared in the vomited matter, and the same was true of a solution of methyl blue. To exclude the possibility of a gastro-colic or duodeno-colic fistula the stomach was emptied by the syphon-tube immediately after the administration of the enema, and in these circumstances none of the drug was found in the stomach contents, showing that it took at least some minutes to reach the stomach. And all possible doubt on the matter is removed by the fact that the patient had on two occasions been submitted to laparotomy without the discovery of anything abnormal. In the light of these and other similar occurrences it is open to doubt whether the ileo-cæcal valve is so perfect a mechanism as the anatomists suggest, and as seems to be demonstrated by the ordinary dissecting-room test. Fæcal vomiting, apart from the use of enemata, also seems to be a well-established fact. In a case described by Jaccoud (quoted in Dr. Murrell's article) a hysterical woman vomited formed motions, cylindrical in shape, brown in colour, and possessing a characteristic fæcal odour. Bregman³ describes a similar occurrence, and on several occasions actually witnessed the vomiting of fæces. Another of the more unusual phenomena of hysteria is anuria, an example of which is reported by Scarpini.⁴ The patient, when 19 years of age suffered from dysuria needing constant catheterism for three months. At 24 she had a sudden hæmaturia without apparent cause. Later she developed hemiplegia which lasted almost eight months and after this anuria was observed. This was associated with œdema of the lower limbs, nausea and headache. Vomiting after food became a constant feature and the vomit had the character and appearance of urine, the quantity being about 400 grams daily. The anuria was practically complete though occasionally a few drops of urine could be withdrawn by the catheter; it did not contain albumen. The bowels were opened slightly once every 15 days or so. There were various disturbances of sensation, but the tendon jerks were normal and no evidence of organic disease could be discovered. Altogether the anuria lasted about two years. Charcot⁵ described a case in which no urine was passed for 11 days, and during this time the patient vomited freely and the vomit contained urea in considerable amount; the natural flow of urine returned spontaneously and the patient made a complete recovery.

¹ Lancet, August 13, 1904. ² St. Bartholomew's Hospital Reports, 1898. ³ Med. Rev., December 1901. ⁴ Brit. Med. Journ. (Epitome), August 13, 1904. ⁵ Diseases of the Nervous System, vol. i. (New Sydenham Soc.).

SOME RARER FORMS OF NEPHRITIS.

IN his Croonian lectures Dr. J. Rose Bradford¹ alludes to some of the less common varieties of nephritis. Apart from gummata and amyloid degeneration of the kidney which may occur in the late stages of syphilis, a nephritis is not very uncommon within two years or so of the date of specific infection. This is difficult to distinguish from other varieties of nephritis and unless the possibility of syphilis is borne in mind it may, when it occurs, be regarded as the result of exposure to cold or wet. But there are one or two clinical features which may help towards a correct diagnosis. Thus the amount