

On Zona. By Professor ROMBERG.

PROFESSOR ROMBERG regards this as a neuralgia, rather than an exanthem. The amount of pain may be excessive, while that of the eruption is trifling; and the pain may be just as intense where no eruption appears. Exanthemata, too, are essentially symmetrical diseases; while this, appearing only on one side (the supposed preference for the left requiring additional evidence), is asymmetrical, like other neuralgiæ. Lesions of the cutaneous nerves, likewise, are not uncommonly accompanied by exanthematous eruptions or pemphigus; and when the neuralgia even arises from internal causes, as that of the fifth pair, the course of the nerves is often reddened. In some cases the pain may persist long after the neuralgia has disappeared, until anti-neuralgic remedies have been resorted to.

The disease is hardly ever fatal; but M. Romberg has met with one case in a child in which it proved so, from the eruption becoming gangrenous. In bad cases he recommends opening the vesicles, and applying the nitrate of silver; but in mild cases, the zinc ointment is a good application.—*Revue Médico-Chirurg.*, viii, 301.

Case of Mental Embarrassment in Orthography. By Dr. FONERDEN.

UNDER the above title, Dr. Fonerden communicates a letter he has received from an individual now in his 25th year, who has found an invincible difficulty in learning to spell, notwithstanding his most strenuous efforts. At the age of seven or eight he could read very well, but he could never spell even the smallest word, except by mere chance, notwithstanding the most diligent application. On this account he was so much persecuted, that he ran away from home, but was brought back, and efforts to teach him abandoned. He went to sea, and practised hour after hour with a dictionary, but could never retain the orthography of words, although, if the incidents he read about excited his attention, he never forgot them. He is very sensible of the mortifications and impediments this defect has given rise to, and applies in this letter for any suggestions that Dr. Fonerden can furnish. The letter is full of orthographical blunders, and the writer says, that were he to write it over again from memory, a great majority of the words would be spelled differently.—*Amer. Journal of Insanity*, vol. vii, p. 73.

SURGERY.

On Bronchotomy in Cœdematous Laryngeal Angina. By M. SESTIER.

THIS is a very elaborate and valuable paper, having for its object the inculcation of a more frequent recourse to operative procedures for the relief of cœdematous laryngeal angina, commonly called œdema of the glottis; a term objected to by Dr. Sestier, inasmuch as the arytenoid-epiglottal folds are much oftener the seat of the disease than the rima glottidis. The author bases his remarks upon 168 cases of the disease which he has collected, in 36 of which the operation was performed, often under very unfavorable circumstances, saving life in 13 and prolonging it in 8, although death eventually occurred. He minutely analyses the circumstances under which the disease occurred, and exhibits the amount of success to be expected from the operation, accordingly as it is applied to the different categories into which he has distributed the cases. He also compares the results obtainable from it in this and in other affections; and finds that, while the operation for œdema is less successful than when it is undertaken for erythematous laryngitis, or for the removal of foreign bodies, it is more so than when performed for croup.

From his investigations it results, that the probability of its success is very much dependent upon the prior healthy state of the larynx, and the fact of the patient not suffering from other serious disease. But he believes it should still be performed even when the œdema is consecutive to severe laryngeal disease, though it

has then succeeded only in 1 out of 19 cases, during convalescence from other disease though it has failed in 4 out of 6 such cases, and when concomitant with various other diseases, though it has then failed in 15 out of 17 times. In fact, he would recommend it in all cases, save when the angina is the *ultimate phenomenon* of incurable and advanced disease, the fatal issue of which would be probably accelerated by it. In several such cases, however, the object would be only to prolong life, and this should be distinctly stated: but in others, apparently desperate, nature's resources would be by it brought advantageously into play.

As to the *epoch* at which the operation should be undertaken, this must *not* be as soon as the disease is recognised, for in 28 well-marked cases it was cured by ordinary means; and these, when energetic, have several times proved of avail even after severe suffocative paroxysms and great intervening dyspnæa have become established. On the other hand, we must *not wait* until it is absolutely certain that the patient will speedily die unless the operation be performed, as he would then often die during or soon after it. We must not be deceived by the dangerous calm which follows prolonged suffocative paroxysm, and is only the precursor of speedy death. It is difficult to fix any precise period; but it may be laid down, that if in spite of active means rapidly employed, the difficulty of respiration continues to increase, the respiratory murmur heard by auscultation becomes more and more feeble, and the suffocative paroxysms are on the increase, the operation is urgently indicated; and it is far more safe to operate *too soon* than *too late*, success being proportionate to the early performance.

There are four circumstances under which the performance of the operation should be hastened. 1. *The debility of the patient at the period of the invasion of the angina*; and doubtless this is the reason why it has so frequently failed, when had recourse to during convalescence from other diseases. The more enfeebled the patient prior to the invasion, the earlier should be the operation. 2. The presence of *deep-seated lesions of the larynx* prior to the invasion. As these have induced the œdema, so will they maintain it. 3. *Œdema of the interior of the larynx*. In 41 autopsies out of 107 collected by the author, partial intra-laryngeal œdema prevailed in 18, and complete in 23, the *chorda vocales* being almost always implicated in both. In four-sevenths of 57 cases of laryngeal œdema, in which the interior of the larynx has been described, this has been present. It adds much to the danger of the case, inasmuch as it is inaccessible to direct applications, and the close texture of the cellular tissue here causes the disease to yield less readily to indirect ones. Its diagnosis is therefore important, and is derived from observing (1), that it never occurs but in patients who were already ill from some cause when the œdema appeared; (2), when found in œdematous angina in connection with inflammation of the fauces, the patients have already suffered from some other forms of disease, and especially from serous diathesis; (3), it has been found in three sevenths of the cases of œdematous angina dependent upon laryngitis, and especially when the serous diathesis was present; (4), the facility of *expiration*, as contrasted with that of *inspiration*, characteristic of ordinary œdematous laryngeal angina, was not observed in seven twelfths of the cases in which intra-laryngeal œdema was present—the obstacle to respiration being then a more fixed one; (5), in 11 out of 12 cases of laryngeal œdema in which the fauces were found infiltrated, the œdema was also intralaryngeal. 4. *Rapidly increasing œdema of the soft parts of the neck*, which renders the operation difficult or impossible.

M. Sestier recommends an operation, even if the patient seems in the *agony of death*, providing this depends upon the œdema itself, and not upon preceding irretrievable disease. Cases are related of life being thus saved. Even when the patient is *apparently dead*, we must not always renounce the operation. A recovery under these circumstances occurred to M. Troussseau; and some of the patients who have died during the preparations for the operation, or just before the arrival of the surgeon, might probably have been saved. If *during the operation* the patient sink as if lifeless, the operation must be rapidly continued, and in this way two recoveries were procured.

In this disease we should always carefully watch the patient, *under the expectation of having to operate.* 1. The course of the disease is frequently excessively rapid. In more than half of 65 cases in which no operation was performed, death occurred at various periods within 24 hours. 2. Certain forms are especially remarkable for their rapid course, as those dependent on inflammation of the fauces, on anasarca after scarlatina, on cachectic diathesis; as also when consecutive to a wound of the neck, with infiltration of blood into the cellular tissue external to the larynx. On the other hand, its progress is slower when it is dependent on deep-seated laryngeal lesion. 3. When the disease assumes the continuous form, it is much more rapid in its course than is the paroxysmal. 4. Sometimes while the patient's condition seems ameliorated, he yet dies suddenly amidst paroxysmal suffering. A remarkable calm after severe paroxysm is sometimes a precursor of death. 5. The nocturnal aggravation of the disease is indubitable, and calls for watching.

Among the varieties of *operative procedure*, the author prefers *crico-tracheotomy*, by which the difficulty often arising from an edematous state of the neck is avoided, and the penetration of air into the veins (this accident occurred twice in the 36 operations, although no mention is made of it in 333 cases of bronchotomy for other affections,) and of blood into the air-passages rendered less likely. It is far easier than tracheotomy, and fitter for the inexpert called in on emergency. He gives minute directions for the performance of the operation; but as these do not apply especially to this disease, we need do no more than refer to them.—*Archives Générales*, tom. xxiii, pp. 385, 420; tom. xxiv, pp. 35, 297, and 441. *Bulletin de l'Acad.*, tom. xvi, p. 117.

[We regret that the great length of M. Sestier's Essay prevents our reproducing some of the statistical data upon which his conclusions are formed. Although, as in all similar inquiries, the absence of records of many facts that have occurred prevents these from assuming the character of absoluteness, enough is assured to justify having a more frequent recourse to the operation in a disease so dangerous, and so often unamenable to both local and general measures. The paper also contains much incidental information of value, which we have not space to notice.]

On the Use of Collodion in Ingrowing Nail. By M. MEYNIER.

M. MEYNIER treats this affection by pressing down the fleshy portion, and pouring in between this and the edge of the nail a small quantity of collodion, which soon solidifies, induces rapid cicatrisation of the ulceration, and, when the disease does not arise from an abnormal shape of the nail, procures a cure. M. H. Larrey has recently tried the plan in five cases, and succeeded in four of these.—*Bull. de Thérap.*, tom. xl, p. 186.

On the Ligature of the left Subclavian, with Post-mortem Appearances.

By J. MASON WARREN, M.D.

In the Periscope of Vol. III, p. 539, will be found a short account of this operation, as performed for subclavian aneurism by Dr. Warren. The artery pursued an abnormal course obliquely across the neck, parallel to the edge of the trapezius, and in company with the cervical plexus of axillary nerves. The ligature was applied between the scaleni, and did not separate until the ninety-sixth day. The patient died of typhoid fever twelve months after the operation. The tumour at the site of the aneurism had disappeared. The subclavian, from its origin to the internal edge of the scalenus retained its normal size, but suddenly terminated there, and became converted into a flat cord of little else than condensed cellular tissue, about one inch and a half in length. The aneurismal sac had contracted to about double the size of the normal vessel, the artery regaining its natural size where embraced by the two heads of the median nerve. The supra-scapular, derived from the transverse cervical, and much enlarged, had, by traversing the external surface of the sac, given

rise at one time, by its pulsations, to the fear of a return of aneurismal pulsation. The vessels of the thyroid axis were double their normal size. The internal mammary was enlarged, and given off by the thyroid; and it was through this, by insulations of the intercostals with the thoracic, and of the posterior scapular with the subscapular, that the collateral circulation had apparently been accomplished.—*Amer. Jour. Med. Sc.*, vol. xxi, p. 53.

On the Reduction of Old Dislocations. By M. MALGAIGNE.

M. MALGAIGNE recently alluded to a case of dislocation of the humerus of four months' standing, which he had reduced with the pulleys; but the reality of which reduction M. Lenoir had doubted, from the fact of finding the head of the humerus projecting somewhat more forward than on the sound side, and considerably more than after the reduction of a recent dislocation. The woman, however, when visited five months after the reduction, was found to have the perfect use of her arm. M. Malgaigne observed, that after the reduction of old dislocations, especially of the humerus, but sometimes also of the hip and elbow, the region does not usually reassume its normal form,—the head of the humerus, *e. g.*, sometimes seeming farther removed from the acromion, and sometimes projecting forwards; while in subacromial dislocation, reduced after a long period, a slight posterior projection remains. If the dislocation has not been very old, these projections may disappear afterwards; but sometimes they persist, without, however, the reduction having been incomplete, or the limb being prevented from recovering its motions.—*Rev. Méd.-Chir.*, viii, 314.

On Ligature in Erections of the Penis. By M. GISTACH.

FOUNDING his recommendation upon ninety cases, M. Gistach directs the individual, in any case in which nocturnal erection from any cause is apprehended, on retiring to rest, to draw the prepuce over the glans, and to fasten it in front of this by a ligature applied only with sufficient firmness to prevent its retraction. He declares the method to be infallible. Diurnal erections that have commenced may be at once arrested, if the attempt to draw the prepuce over the glans be made soon enough to avoid compressing this part, which would only increase the suffering.—*Bull. de Théráp.*, t. xxxix, p. 475.

On Median Lithotomy. By Professor RIZZOLI.

THE perineal urethra being well projected-out by a very convex sound, the operator commences his incision of the superficial coverings a few lines behind the base of the scrotum, and carries it to the margin of the anus. Passing the nail of his left thumb or finger under the bulb of the urethra in order to protect it, he feels for the groove of the sound, and penetrates the anterior part of the membranous portion of the urethra with his lithotome; the ligature or torsion being applied to any of the arterial branches proceeding towards the bulb, which, owing to their abnormal development, may bleed too freely. Having implanted the point of his bistoury within the origin of the membranous portion, in order to prevent any injury to the rectum, the surgeon now takes the sound from the assistant, and raising the handle to a right angle with the pubes, enables the instrument to slide under the pubes, rendering the membranous portion prominent, and its division easier, without injury to the rectum. The incision should be carried far enough to scarify the edge of the prostate, as urinary effusions into the cellular tissue of the anterior walls of the pelvis are much more likely to occur when it is limited to the membranous portion, and the dilatation of the part by the passage of large calculi is then more difficult. The incision completed, the operator passes his index finger into the wound, with the palmar surface upwards, guiding it along the groove of the sound into the bladder, and making it serve as a conductor for the passage

of the forceps. If the surgeon discover for the first time, during the operation, that he has to do with a very large calculus, it is better to break it prior to removal, for which purposes Professor Rizzoli has contrived an instrument.

He believes the advantage attendant upon this mode of operation to consist in avoiding wounding the bladder, rectum, bulb, vasa deferentia, the great perineal arteries, or the prostatic venous plexus. He has as yet operated in this manner only upon eight patients, but in all with success. In one of his cases there had been originally two calculi in the bladder, one of which was discharged by an aperture produced by Nature in the perineum.—*Bulletino delle Sc. Med.* vol. xvii, 271.

On Effusion of Blood into the Interior of the Eye. By M. TAVIGNOT.

If in these cases the eye is in a normal state, in all respects save the hypæmia, the blood will be most readily absorbed under the most simple treatment; but if the organ is the seat of severe pain, congestion, or inflammation, it may persist indefinitely until these conditions are removed. The affection may be treated according to the nature of its cause.

1. *Essential hypæmia.* This is of rare occurrence, and consists in an effusion of blood into the eye, in the ordinary circumstances of health, and without appreciable cause, not being symptomatic of a general disorder of the economy, as scorbutus, or dependent on deviation of menstrual action. A case occurred at the Necker, in 1843, in a woman, æt. 65, presenting no sign whatever of disease, and who was unable to assign any cause, notwithstanding the most careful interrogation. She had complained for two days, rather of uneasiness in the eye than of pain, and no signs of contusion were present. The organ was in a completely normal condition, except that the lower third of the anterior chamber was occupied with blood. Mere purgatives were given, and in twelve days the blood had all disappeared.

2. *Traumatic hypæmia* is of more frequent occurrence than all the other varieties put together, and may be induced either by a cutting instrument or contusion. In itself the effusion is of no consequence, the degree of injury the different tissues have undergone being the really important point. The harmlessness of almost all lesions of the iris, except puncture, is remarkable; and thus sections, lacerations, and contusions of the part may occur without phlegmasia being induced. A case in point is related. A quarryman was struck while blasting a rock. The eyelids were ecchymosed, but both the sclerotica and cornea were in a normal condition. The anterior chamber being full of blood, the patient could not distinguish objects, but complained of a sense of distension rather than of pain. Being young and strong, he was bled and purged, and in five days no blood remained. The iris was now observed to be separated from the ciliary body on the inner side, the upper side, and the external and somewhat inferior side, so that three artificial pupils resulted from this singular lesion, the natural one still being preserved.

3. *Inflammatory hypæmia.* Von Ammon has described the escape of blood from the inflamed iris, and its accumulation in the anterior chamber, and Lawrence says the inflammation need not be very severe to produce it. It is of importance to remember that this may be one of the initial symptoms of iritis. The author relates an interesting case occurring in a lady, æt. 50, in whom, twenty-six days after a successful operation for artificial pupil, he broke up a soft lenticular cataract, 30th July, leaving the fragments *in situ*. She went on very well until the 12th August, when, after errors of diet, the iris became vascular, and a bloody dew exuded from its surface, a small collection of blood being also observed in the lower part of the chamber. On the 14th and 15th pus became mingled with this, and by the 16th predominated; but prompt salivation soon induced absorption of the deposit. M. Tavignot has met with three analogous cases.

4. *Hypæmia from spontaneous vascular rupture.* Two cases are related. The first

occurred in a patient suffering from a deformity of pupil produced by adhesion of the iris to a cicatrix of the cornea, and belladonna having been dropped into the eye for a considerable period, the pupil became rounded while the anterior chamber was found to contain blood, which had proceeded from rupture of vessels during the forced dilatation of the pupil, by means of the belladonna. It was soon reabsorbed. In the other case the effusion was consequent upon the sudden destruction of an adhesion which had taken place between the iris and an opaque capsule.

5. *Hypæmia from ulceration.* But one example of this has occurred to the author. A man, æt. 40, suffered from severe pain and obstinate vomiting, after depression of cataracts, 19th of June. On the left side the lens in part remounted, nearly obliterating the pupil, and causing severe pain. By the 20th of August the pain had become violent, and a very large collection of blood took place in the anterior chamber, but, in a day or two, was in part resorbed. The rest remaining stationary, an opening was made 14th September, and it was discharged in a fluid state. An erosion or ulceration was afterwards perceived on the inner part of the lesser circle of the iris, induced, apparently, by the pressure of the reascended lens.

6. *Hypæmia from organic lesion* is a secondary accident, consequent upon various affections of the globe.—*Gaz. des Hôp.*, 1850, Nos. 81 and 84.

On the Employment of Collodion in the Production of Artificial Ectropium.

By M. CUNIER.

THE obstinacy with which adhesions are almost invariably reproduced after the division of the tissues, constituting *symblepharon*, is known to all surgeons; and numerous have been the operative procedures contrived to prevent this. To all these, M. Cunier prefers the employment of collodion. After dividing or dissecting away the adhesions, the eyelid is maintained everted, by connecting it with bandlettes of linen soaked in collodion to the frontal region, or the cheek, as the case may be. In three cases in which the plan has been tried, it has quite succeeded. In two only, the extroversion was maintained permanently for nine days, then for some hours during the day, and all night for three weeks, and then occasionally. In the other, a much shorter space of time was required. The bands require readjusting every morning; and the eye is protected by allowing a compress to hang down before it. In the same way, the *conjunctival bridles*, which are so common in Belgium, as a result of the inadvertent use of caustic, may be treated; and the management of *ankyloblepharon* is thus also simplified and rendered more certain. Dr. Cunier has also employed this mode of eversion in the management of voluminous granulations and vegetations—especially those of the upper lid; and the result of six months' observation convinces him that cauterization by the nitrate of silver, and the application of the acetate of lead, exerts a more rapid and complete effect, in proportion to the time the eyelid is thus maintained continuously everted. In this way many old cases have been unexpectedly benefited.—*Annales d'Oculistique*, t. xxiv, pp. 186-94.

On Fracture of the Thyroid Cartilage. By M. EICHMANN.

IN this paper M. Eichmann relates the pathological appearances found in one case, and the particulars of the recovery which took place in another. In the first, the child died with the symptoms of suffocation from *œdema glottidis*, laryngotomy having been refused. A double fracture was found,—one producing a detachment of the arytenoid cartilage from the upper edge of the cricoid, and the other penetrating the thyroid at the point of insertion of the thyro-arytenoid ligaments. Extensive œdema, consisting of sero-purulent infiltration, had very rapidly formed. The cause of the fracture is not stated.

The second case occurred in a girl, æt. 9, who fell upon the sharp edge of an iron chest. Among other injuries, the reporter found a complete fracture of the thyroid, which divided the cartilage along its middle on one side, and extended somewhat over

the other. There was much displacement inwards, and so much bleeding, that an arterial branch, apparently the superior thyroid, was tied. After a while, convulsions came on, together with a violent cough, which expelled frothy blood from the mouth. Some leeches and an anodyne emulsion were ordered; but the cough recurred every few minutes, accompanied by a frightful *siffllement* and *râle*. Respiration now became difficult, the eyes projected, and the veins of the neck were distended from the increasing impediment to the return of the blood. As life was obviously in danger, laryngotomy, by means of an aperture in the crico-thyroid ligament, was resorted to, and gave rise to great relief. As, however, the space between the cartilages was unusually small in this child, a section of two lines of the anterior arched portion of the thyroid was made, and a bent polypus-forceps being passed in the dislocated portion, was carefully elevated. The artificial opening was purposely kept open for a fortnight, and air only entirely ceased to issue hence at a considerably later period. The cartilage was quite healed in six weeks, the voice being then unaffected, and the respiration only slightly embarrassed.—*Med. Zeit.*, 1850, No. 29.

On secondary Syphilitic Sores of the Penis. By Dr. GAMBERINI.

DR. GAMBERINI communicates notes of several cases, in which he believes that syphilitic sores appeared on the glans or prepuce, as a secondary, not a primary symptom. One of the chief distinctive characters is, that while a primary sore commences as a pustule, a constitutional one commences with a circumscribed, deep, almost purple redness, which is soon followed by abrasion of the epithelium, and ulceration, as in syphilitic sores of the throat. Compared with the primary sore, the secondary one is of very short duration; and it does not give rise to a venereal bubo. Thus, when we see a man with a sore on his penis, we are not at once to conclude that he is the subject of a new infection, but should inquire into the history of its appearance.

He takes this opportunity of stating, that of 100 cases of constitutional syphilis observed promiscuously in the Venereal Hospital at Bologna, some of the symptoms indicated by Ricord as *tertiary*, were developed in 52, without any *secondary* ones having intervened between them and the primary. In the other 48, too, the secondary were in several cases so rapidly followed by tertiary, that the two might be considered contemporary. He believes that mercury is the most important medicine, not only for secondary but tertiary symptoms, since three fourths of the patients are cured by it, and the other fourth, who recovered under iodide of potassium, have, for the most part, formerly derived advantage from the mercury, and now apply on account of relapse of the tertiary symptoms.

Other points, in which he differs from M. Ricord, are constituted by his belief in the possibility of the occurrence of secondary symptoms after gonorrhœa, independently of any urethral ulceration, and of the occasional production of primary venereal bubo, unpreceded by sores on the penis,—the “*bubo d’emblée*” of the French. Of both these circumstances he relates some cases in this paper.—*Bulletino delle Sc. Méd.* vol. xvi, pp. 351—381.

MIDWIFERY, &c.

On the Round Ligaments of the Uterus. By M. RAU.

In this paper M. Rau refers, at great length, to the various opinions that have prevailed respecting the structure, functions, and diseases of the round ligaments; but we have only space to refer to his own views. In regard to their *structure*, he considers that, for two thirds of their course, they are composed of a continuation of the muscular substance of the uterus, over the anterior and posterior surface of which they are expanded fan-like, reaching to its fundus, and encom-