

The swelling on the left side was supposed to be the spleen. No improvement resulted from medical treatment.

On July 9, I punctured the liver in its most prominent part, just to the right and a little above the umbilicus. No serum or pus was found, and as the patient was very weak and not under an anæsthetic I did not explore the liver so fully as I desired. No pain or ill effects were experienced from the puncture. He rallied for a few days and died suddenly on August 26.

Autopsy eight hours after death, present Drs. Sherman, Quirk, Meyers and Hornibrooke. Heart and lungs normal. The friends had stipulated that the head should not be opened. The abdominal cavity contained a small quantity of serum. The liver extended as low as the umbilicus and across the median line, filling the left hypochondrium and pressing against the spleen, which was of normal size and consistence. The stomach was behind the liver, which seemed hollowed out to receive it, and with the sulcus in front, gave the two parts somewhat the appearance of the old-time physician's saddle bags; heavy and large at both ends and slender in the middle. We could find no trace of the puncture which had been previously made. The margin, especially near the epigastrium on the right side, was hard, the inferior surface concave. The whole of the lower surface of the liver was studded with whitish, slightly yellowish, flattened vesicles (hydatid), filled with a whitish fluid. Several hydatid cysts as large as a coffee cup were found in the substance of the liver, filled with a fluid similar in appearance to that found in ascites. The gall-bladder contained bile and we observed no obstruction to the duct.

Cherokee, Dec. 10, 1885.

CORYZA, ITS CAUSES AND TREATMENT.

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OF NEW ORLEANS.

This affection has hitherto been regarded as a disease of comparatively minor importance; yet, latterly, owing to advances and improvements made in the modern method of treating processes, as well as the extravagant dissipation of the majority of the laity, as also the subsequent effect upon a constitution improperly developed physically, not being inured to the transitions of temperature by suitable clothing, we find that the disease prevails almost universally, becoming more prevalent in warm latitudes, where hitherto, it was seldom prevalent. There has been, quite justifiably, an impression among the body politic, that a cold in the head (which is a decided misnomer) was nothing in entity, but could be readily relieved, and permanently.

Among the many features provocative of this malady, extraneous to hereditary influences, I am constrained to accredit the habit of smoking, as being the source of the majority of the most aggravated cases. So many of the younger men mistake their nasal appendage for *smoke stacks*, that they essentially become victims to the relaxation subsequent to the

stimulant influence of a steady stream of hot smoke through the nasal passages. This relaxation ultimates in a species of hypertrophy of the Schneiderian mucous membrane, and of the continuity of the turbinated bones, where virtually exists the disease denominated catarrh. In my practice, I have had, numbers of cases under observation which I have denominated "*smoker's throats*," implicating the posterior fauces, palatine arches and walls, the uvula, the turbinated bones, the Eustachian ducts and the epiglottis and trachea. The mucous surfaces were excoriated almost literally, the catarrhal phenomena were typically troublesome, and provoked an insatiable desire to clear the windpipe; and owing to a decided narrowing of the canal (nasal), induced a form of dyspnoea, which has been denominated nasal asthma. The ingress of the volumetric pressure of air is far greater than the outlet at the posterior nares, due to an hypertrophied condition of the turbinate ossific vaults. The excoriation undergoing cicatricial restitution ultimates in a pachydermatous condition, compromising the normal nasal secretions, as also stillicidium, which indicates a fulness or thickened condition of the membrane, closing the *ductus ad nasum*.

Atmospheric influences are most proverbially provocative, those extraneous to direct exposure, such as passing from heated to cold atmospheres, also after becoming superheated, then removing surplus clothing and having the action of the skin suddenly checked. Dusty atmospheres, especially, caused by rolling cotton bales, rice or coffee mills, lime-kilns, shell roads, pikes, flouring mills, mop factories, enclosed saw-mills, grain elevators, and ship-holds when being loaded with cotton or bulk grain. Our shelled levee, with the slightest breeze, envelopes everything in a dense cloud. All sorts of particles wafted promiscuously are potent irritants, first by such a quantity being inhaled and deposited upon the mucous surface, causes an acute secretion, and by a continuance or repeated attacks similarly entail a chronic exudative rhinitis, which ultimates in an œdematous condition of the membrane, and finally implicating the nasal canal, and inducing really a form of acute osteitis, or hypertrophy of the turbinate bones, which sometimes exfoliates and suppurates, and chronic ozoena results.

Having enumerated various causes of this malady, and having given, to some degree, the pathology of this annoying complication, the treatment is next of vital importance. Nasal douches without number have been directed against this anatomically delicate canal, and with detriment ultimately. Such are not beneficial, simply because of the difficulty of keeping the Schneiderian mucous membrane saturated (so to speak) with any medicament; and furthermore, the forcible contact of the steady stream serves to enervate and ultimately to relax completely, from the subsequent engorgement. Vile irritant snuff compounds have been sold, and with no benefit. Unscientific appliances have been manufactured, and recommended for use, directing the same upward instead of *horizontally*, to reach the imaginary locality of the disease.

I greatly prefer the inhalation treatment, either by evaporated medicines, or by the insufflation of some emollient substances. Astringents, strictly vegetable, are not indicated for permanent use. I have found subnitrate of bismuth to be the most soothing, and absorbing the profuse nasal secretion relieves the irritable mucous membrane, when the defluxion is offensive; then a small quantity of iodoform combined with it deodorizes the discharge, which is removed by hawking. The bismuth deodorizes the iodoform, and its peculiar odor is not perceptible after a short while. My plan is to clear the canal, and inhale my powder only at night, retiring as much as will remain upon the end of a match. My formula is

R. Bismuth subnit. ʒi.
Iodoformi, ʒij.
M. and pulv. Sig.—Locally.

This has never failed to relieve any case coming under my observation.

MEDICAL PROGRESS.

THE SURGICAL, PHYSIOLOGICAL AND ÆSTHETIC ADVANTAGES OF THE ARTIFICIAL VITREOUS BODY.—DR. P. H. MILES read a paper on this subject at the last meeting of the British Medical Association. Sympathetic ophthalmia, or disease of a sound eye, caused by injury to its fellow, was brought to the notice of the profession by Mackenzie, of Glasgow (*On Diseases of the Eye*, 1840). He referred to it as well known to his colleagues and himself, and, as the name implies, attributed it to nerve-sympathy, or in modern terms, a "reflex neurosis." This theory held general acceptance until a very late period; and even now there are many believers in the sympathetic origin of the disease. Be that as it may, a school has arisen which refers the disease to "bacteria" having its first point of localisation in the uveal tissue, there producing a specific uveitis with germs, "bacteroid bodies," capable of self-propulsion along the perineural lymph-spaces of the first affected eye, across the chiasma, and down the lymph-spaces of the sound eye, reproducing a similar affection, often with disastrous results. Holding this view, I designed, for the prevention of sympathetic disease, or, as we now term it, "secondary septic ophthalmitis," the operation of "evisceration of the globe," on the lines hereinafter laid down, to be associated in suitable cases with the use of the "artificial vitreous body."

It is right here to state that the operation of "evisceration" has been occasionally practised by surgeons as an emergency-treatment, but the perfecting thereof, and the rules for its safe performance, were placed upon a secure basis by Dr. Gräfe, of Halle, and myself during the year 1884, working independently of each other. To our illustrious countryman, Sir Joseph Lister, we are indebted for the antiseptic treatment which alone makes this operation feasible. Perfect faith in the bacterial origin of this affection led me to the steps hereinafter named; for it was not enough to eviscerate the intra-ocular contents, and leave only

a small button of sclera on which to plant an artificial eye (immeasurably superior as it is to the operation of enucleation); and, following out the logical sequence, that total exemption from the dangers of sympathetic disease being assured by early removal of all the uvea, the introduction of a permanent hollow glass sphere within the denuded sclera could produce no ill effects, the result has fully realised the most sanguine expectations. To attain this end, the following steps carried out with a scrupulous attention to detail, are necessary. Any eye may be eviscerated, except such as are infected with tubercle, glioma, or any other known malignant growth. Small stumps, when painful, can be opened, cleansed, bone or foreign bodies removed, and the pain and uneasiness disappear, leaving a smaller stump, but safe from danger to the sound eye, except in those instances where bacterioid bodies have travelled beyond the globe. Even then it is a fair assumption that no more harm could possibly accrue than if the stump was enucleated.

The instruments necessary for the due performance of the operations are: 1, a hand-spray; 2, a siphon-tube of India rubber to flood the eye after or during operation; 3, an ample supply of solution of corrosive sublimate (1 to 1,000); 4, an eye speculum; 5, fixing and dressing forceps, two pairs; 6, a Gräfe's knife; 7, a spoon to evacuate contents (Bunge, of Halle, has devised an instrument, but any scoop answers equally well); 8, needles threaded with chromicised catgut (fine size); 9, artificial vitreous bodies in assorted sizes; 10, dressings; namely, iodoform, wood-wool pads in Lister's gauze, oiled silk, glycerine, boracic or sublimated bandages.

The operation is divided into two parts. The first part, complete in itself, is evisceration. It is conducted as follows: 1. Anæsthetise the patient. 2. Use the hand-spray, and thoroughly cleanse and disinfect the appendages with 1 to 1,000 solution of corrosive sublimate. 3. Transfix and remove the front of the eye with a Gräfe's knife at the corneo-scleral margin, cutting round the conjunctiva first. 4. Empty the contents of the globe in any way that is convenient, taking special care to remove the ciliary body and choroid, leaving a clean white sclera. 5. With a thin India-rubber tube (Inst. 2), used siphon-wise, run the sublimate solution into the emptied globe; during the performance of the operation, it will help to arrest bleeding. 6. Select the needles, slightly curved, for sewing up, and threaded with gut. And here, if we please, we may leave the patient, secure in the knowledge that sympathetic disease will not attack the other eye, except under most exceptional circumstances, and that he will possess a movable, though very small, stump on which to adjust an artificial eye; but where a perfect æsthetic result is sought for, and especially in children, for reasons hereafter stated, we advance another stage, and before sewing up the sclera. 7. Take the glass sphere best suited to the case, slit the sclera vertically, until the sphere will with difficulty enter the cavity. This difficulty only refers to introducing the globe; when it is in, the sclera should unite easily without any tension, and leave no awkward angles; therefore the