

iris, can be more readily understood than described.

2. If the corneal incision and iridectomy be made before the laceration of the capsule, the cornea becomes hazy owing to the escape of the aqueous and the effusion of blood from the incised parts into the anterior chamber. This film of blood beneath the cornea completely obscures the lens and the iris from the operator's view.

Under such circumstances, even a practised operator is sure to bungle in groping his way to the lens with the cystitome. Hence the laceration of the capsule cannot but be anything but satisfactory.

3. This modified operation does not interfere with the structure of the iris in the least, and even a cocainized patient can go through the whole operation without any pain at all, and can get over the effects of the operation as though no operation was performed on him. Hence the chances of iritis, the most formidable enemy after cataract operations, are reduced to a minimum.

4. This operation requires great care and delicacy in manipulation; when successful it gives very satisfactory results, especially in the saving of time and in not adding a permanent and conspicuous blemish to the eye.

5. The shoulder of the cystotome is the most lurking place for some decomposing residue of a former operation; and, in spite of especial care in cleaning, this part of the instrument will never come up to the standard of surgical cleanliness. The same may be said about the teeth of iris forceps, if iridectomy were to form part of an operation. The sooner these instruments are done away with in cataract extractions the better will be the chances of success.

Let me now place before the readers the results of my own experience, though short it be. I have adopted this modified form of operation without iridectomy in almost all the cataract cases among the ryots of this place during the last seven months, and the results were marvellous, indeed without a single failure. The analysis of my cases will be published later on. The notes of these cases are less complete than I could wish not having been taken with any view to publication, and are defective from the omission to record the final result in vision.

I failed with my naked eye examination to make out any difference between the eyes operated upon and the sound ones, beyond the fact that the pupils in the operated eyes were of a darker shade. The pupils readily responded to actinic influences and to the action of mydriasis. Almost all my patients being illiterate I could not test their vision with Snellen's test types, but I should think the visual results were excellent in almost all the cases, even beyond my expectations.

The modified operation I have described has proved to me a faithful servant, and will, I trust, prove to be so to others until a better method can be invented.

ON THE USE OF METHYLENE BLUE IN MALARIAL FEVERS.

BY SURG.-CAPT. D. G. MARSHALL, M.B., C.M., I.M.S.,
AND SURGEON-CAPTAIN F. W. GEE, M.B., B.S., LOND., I.M.S.

DURING the past two years we have made an extensive trial of methylene blue in the treatment of malarial fevers, on both European and native cases, and from the results obtained are of opinion that, in many cases, it is a valuable remedy, and that its therapeutic properties deserve wider recognition. Ehrlich has used the drug in a few cases in Germany, and found that the development of malarial plasmodia in the blood was arrested, and their number quickly reduced by its administration.

The dose used by us in all cases was two grains given as a pill in combination with extract of gentian or hyocyamus; the latter drug being indicated in cases where the exhibition of methylene blue was followed by symptoms of irritation of the bladder and rectum. One pill was given every two hours, with a maximum number of five during the day.

We found, as a rule, that after the temperature had fallen to normal, the amount given could be decreased daily and finally discontinued about the fourth day: also that it was seldom necessary to administer the maximum amount for more than three days.

Our experiments with methylene blue have all been made in Baluchistan where the prevalent fever is of a type peculiar to itself, and is not generally ushered in by a cold stage; the onset of fever being usually sudden and manifested by rapid rise of temperature accompanied with headache and muscular pains, pyrexia usually continuing for several hours, and the sweating stage not marked.

In these cases quinine and antefebri frequently fail to check the progress of the disease, while, on the other hand, the administration of methylene blue is often followed by most satisfactory results, the temperature falling to normal in a few hours, and the progress of the disease in many cases completely arrested.

In some cases of remittent fever, characterised by persistent high temperature and unaffected by the ordinary remedies, the results obtained by the use of methylene blue were immediate and lasting, but in other cases of the same character it did not produce any beneficial effect.

The use of this remedy is occasionally followed by more or less marked symptoms of irritation of the bladder, and also, in a few cases of the rectum, which can usually be combated by the exhibition of hyocyamus and potassium bromide,

though in two cases the vesical irritation was sufficiently severe to cause retention of urine. The most striking and immediate result of a dose of methylene blue is the change in colour of the urine, which generally within two hours assumes a deep blue; in cases where vomiting occurs the vomited matter is also deeply stained; patients are often much alarmed by these appearances and should be forewarned. As the result of our clinical investigations on this remedy, we have arrived at the conclusion that, though not a specific in all cases of malarial fever, we possess in methylene blue a therapeutic agent of great value, in many cases which resist the ordinary methods of treatment, and deserving a more extended trial, which we trust it may receive at the hands of some of your readers.

A Mirror of Hospital Practice.

A CASE OF ENTERIC FEVER IN A GURKHA.

INTESTINAL HÆMORRHAGE—DEATH.

BY SURGEON-CAPTAIN ROBERT BIRD, I. M. S., M.D., M.S. (LOND.), F.R.C.S., D.P.H. (CANTAB.), *Civil Surgeon, Kohima, Naga Hills, Assam.*

No. 855, Sepoy Runbir Thapa, Naga Hills, Military Police, was admitted on October 29, 1892, to the Police Hospital, Kohima, with the history of continued fever and diarrhœa for about a fortnight.

He had been stationed in a Naga village on punitive duty with a detachment. The fever and diarrhœa had come on gradually, and had continued steadily. At first he had struggled against it and done his duty. At the end of a fortnight he walked in 21 miles to head-quarters and reported sick. He was found to have jaundice of some days' standing. He was emaciated and weak, with frequent soft pulse. Respiration was not markedly increased. Temperature 103° F. The abdomen was rounded, but not tense or distended. Some pain was complained of over the liver and spleen, but none was referred to the right iliac fossa. The abdomen was mobile during respiration, and not tender to the touch. The spleen was felt to be somewhat enlarged and tender. There were no spots or eruptions over the abdomen. The tongue was red at the tip and edges, and covered over the centre with a thick yellow fur. The bowels were moved about seven times, the motions being yellow, semi-liquid and containing undigested rice. No history of any special form of sickness in the village was obtained.

The case was considered by the Hospital Assistant in charge to be one of continued fever. The temperature on admittance was 103° F. Castor oil and santonine were given as intestinal parasites were found in the stools. Quinine and antipyrin were given for the fever. Milk and

whiskey, 2ozs., were given, but solid food was not interdicted although the patient had no appetite. Bromide was given for the slight nocturnal delirium, and an astringent mixture for the diarrhœa.

Two days after the case was seen by the writer, and the appearance of the tongue was so suggestive of enteric cases in England that solid diet was interdicted, and milk given in increased quantities.

On November 4, 1892, asthenia was increasing. There were sordes on the lips and tongue, the pulse was losing strength and gaining in rate, the first sound of the heart was becoming inaudible, the delirium was passing into coma vigil, the temperature remained at 103° and was not influenced by drugs.

On the afternoon of November 5, 1892, melæna was reported. The stools on inspection were found to be almost solid clots of blood retaining the shape of a mould of the colon.

Stimulants, ergot and pill of acetate of lead were given. Blood continued to ooze from the anus, and the patient died the next day.

Post-mortem 12 hours after death. Body emaciated, jaundiced. Bright blood issuing from anus. On opening the abdomen the whole of the large gut and about ten feet of the small gut above the ileo-cæcal valve was of a glistening maroon colour and tense from the clotted blood contained in them.

Commencing from a point twelve feet above the ileo-cæcal valve the mucous membrane, as a whole, was much injected. The agminate and solitary glands were swollen like peas in the mucous membrane. Many of them had necrosed, and in some the sloughs had separated, leaving circular, clearly-cut ulcers of varying depth, the edges being a little overhanging.

Peyer's patches showed the same condition in various stages of development. Some were tumefied, others were sloughing, from others the sloughs had separated, leaving large longitudinal ulcers opposite the mesenteric attachment. In some cases the peritoneum was exposed at the bottom of the ulcers. At the ileo-cæcal valve were three large confluent ulcers which seemed about to penetrate the peritoneal coat. Opposite to this patch in the mesentery was a lump of glands as large as a walnut. All the mesenteric glands were much swollen and softened. No peri-adenitic suppuration was found. The site of hæmorrhage was not found. The large gut beyond being stained by the colouring matter of the blood was normal. Spleen was large, soft, friable. Liver was of the usual size, no duct obstruction being found. Kidneys, enlarged and soft; heart, dilated, flabby, pale; lungs, congested.

This case is of interest as showing that the incidence of disease in the Gurkha tends to be the same as that of the European. (Cf. Dr.