difficulty and pain in passing water, and on examination found a complete renewal of the displacement. Mrs S. had risen for a little, and this had proved sufficient to induce a relapse. Replacement was again easy, and after it I stuffed the enlarged vaginal canal with linen, a couple of handkerchiefs being greedily devoured. Enjoined rest for a day or two.

There was no renewal of the deviation, and patient went to the full time, and had a very speedy labour on the 10th of July (1864).

I may mention that Mrs S. is one of those desirable patients who have remarkably speedy labours, her children, owing to superabundance of pelvic room, coming home almost before one, however Jehu-like he may hasten, can arrive on the scene.

CASE II., *12th July* 1865.—Called to see Mrs L., pregnant for the fourth time. Woman with large pelvis, of pale complexion, and flabby muscles. Had suffered for a day or two from pain in evacuating bladder; urine only dribbled away. Had tried the Cockney's panacea—gin, but without any relief,—nay, apparently with aggravation of the distress. Inquired if she had been exerting in any way, lifting heavy weights, etc., but she could not recollect of such. An examination immediately revealed retroversion. The fundus was pressing on the rectum, and the os, somewhat indurated, bearing on the bladder, though only slightly; flexion existing to some extent. On passing the catheter, which entered easily, a good deal of water came away, but not so much as I expected from the history of the case. It was clear that, owing to the flexion, the pressure of the os on the urethra had not been very great. I pressed on the fundus, the patient being on her side, but it ascended slowly. I then altered her to Sims's favourite posture, and found it to enhance very much the facility of reposition, much less force being required, and the organ making a speedy and sonorous ascent. Plugged the vagina, and ordered rest. The former was retained for a day or two, but the latter was not carried out. There was, however, no return. Patient went to full time without further trouble, and was delivered on 4th January 1866, the labour being easy and short. I had anticipated this, and, although early on the ground, had only to superintend the third stage.

ARTICLE VII.—*On Œdema of the Conjunctiva as a Symptom of Surgical Fever.* By LAWSON TAIT, L.R.C.S.

IN the January number of the *Edinburgh Medical Journal*, a case of cerebral abscess is narrated by Dr S. Lawrence. One of the symptoms described was, that "his left eyelid was œdematous and erysipelatous," with a footnote to the following effect:—"The

swelling of the eyelid, which, it will be observed, occurred again and again in the history of the case, is a curious phenomenon, not very easily accounted for. In the discussion which followed the reading of this case, Dr P. H. Watson observed, that 'in many cases of intracranial injury or disease, there occasionally occurred great tension of the parts within the orbit, with protrusion of the globe of the eye; and he considered that such changes were due to *thrombosis* of the cavernous and ophthalmic sinuses, which might or might not be accompanied with purulent formation external to the vessels; and that the œdema of the lids and cellular tissue of the orbit was in this way occasioned by interruption to the venous return.'

"A mechanical cause is thus assigned for the swelling of the palpebræ. I am not aware whether such a symptom has been often observed by medical practitioners in connexion with cerebral affections. In only one other case has it happened to myself to witness it. A child, three to four years of age, sickened in the course of the afternoon, and, as the day advanced, complained of headache; then drowsiness and swelling of the left eyelid supervened, followed by convulsions and death within an hour or two after."

This is the only notice that I have met with of a condition that has come three times under my notice within the last three years, and, as an introduction to the subject, I shall briefly narrate the cases.

I. Martin M., æt. 23, met with a railway accident, which rendered it necessary for me to amputate his left leg below the knee. On the 8th day there was no suppuration, and only a slight serous oozing, which contains some *debris* of blood-corpuscles but no pus-cells; this was due to the fact that acupressure had been employed. On the 14th and 15th days he had rigors, occasioned apparently by a water-pillow having been chilled. On the 16th day there was some unhealthy discharge from a corner of the wound; his pulse was 140, tongue brown; ordered quinine, opium, and wine. 18th day, pulse 150 and very weak. 19th, pulse 120, and he is much better. 20th, worse again, pulse 150, *subsultus tendinum*. At night there seemed to be a slight paralysis of the right side of the face. 21st day, the paralysis was quite distinct, and seemed to be spreading over the right side of the body. The right eyelid was drooping, and when the buccal test was applied, the right side leaked. The conjunctiva of the right eye was curiously œdematous and there was profuse lachrymation. The stump had opened almost throughout its extent, and the ends of the bones were seen to be covered with firm healthy granulations. There was no delirium, but some difficulty in understanding what he said. In the evening he seemed to be sinking, and died on the morning of the 22d day. No examination of the head could be obtained. The vessels of the stump I procured, and found that they were perfectly secured by fibrinous adhesion.

II. John D. sustained a severe compound fracture of the right

leg. I put the limb in a Salter's swing, and the case did well until the 17th day, when he had a rigor. On the 18th, his pulse was 140, and he complained of pain in his head; tongue brown, and troublesome hiccup; ordered ice, wine, quinine, and opium. On the 19th day there was slight œdema of the conjunctiva of the left eye, and profuse lachrymation. 20th day, the œdema had increased; he was perfectly conscious, but evidently sinking. He died next morning, and the body was examined twenty-six hours after death. Nothing was found abnormal in any organ; neither in the lungs, kidneys, nor liver, were there any of the usual secondary abscesses. The brain was normal, except a slight venous congestion. The cavernous and circular sinuses, and the anterior part of the inferior petrosal sinus when slit up, were seen to be filled with loose thromballotic debris; the lining membrane was much altered in appearance. These appearances extended into the ophthalmic vein.

III. John G., æt. 42, was pitched out of a gig, and is supposed to have lit on the top of his head. He was insensible when I saw him, and soon after had a severe epileptic fit, although he was never known to have had anything of the kind before. His left clavicle was fractured at the middle, and he was bleeding from both ears; diagnosis recorded, fracture extending across both petrosal bones. On the 2d day he had another epileptic seizure, and after it became very delirious; the bleeding from the ears was replaced by a serous discharge, which made the diagnosis certain. 3d day, no more fits; serous oozing ceased from the right ear, but it became purulent from the left. He was less delirious, but not yet sensible; head shaved and ice applied. On the 6th day he was quite sensible; profuse purulent discharge from the left ear, and an abscess was forming in the fascia above it. 9th day, opened the abscess in the morning at 8.30 P.M.; he had a violent rigor, and immediately became delirious; left pupil perfectly paralyzed and widely dilated; ordered calomel gr. vi. 10 P.M., temp. axillæ 103·7°. 10th day, much better; temp. 101·2°; left pupil acted sluggishly, and was markedly more dilated than the right. Ear was discharging healthy matter copiously. He was quite conscious, and eating well. 16th day, he went on well till 3.30 P.M., when I saw him in a severe rigor, immediately after which the temp. axillæ was 102°. 17th day, much better, pupils normal; temp. 102·3°: *vesp.*, conjunctiva of left eye was noticed to be œdematous. 18th day, conjunctiva more œdematous; slight hay odour of breath; diagnosis recorded, inflammation of the left petrosal sinus spreading forward towards the left ophthalmic vein; prognosis, very unfavourable. *Vesp.* 10 P.M., breathing oppressed, probably from pleurisy, intense hay odour of breath; left conjunctiva intensely œdematous, right slightly so, and in both eyes there was profuse epiphora; diagnosis, that the inflammation has spread along the circular sinus into the right cavernous sinus; temp. 102·3°; slight delirium and slight diarrhœa. 19th day, very much worse, but less delirium. 20th day, died at 10.30 A.M.

I examined the body the same day at 6.30 P.M., and found that in the lungs only there were secondary abscesses, and these were in the first stage, small in size, and few in number. The liver and kidneys were quite normal. There was a small spot of the brain over the left petrosal bone affected with inflammatory softening. A fracture of the base of the skull existed, extending completely through the left petrosal bone, across the basilar process of the occipital, and considerably into the right petrosal. The left petrosal, right and left cavernous and circular sinus, were filled with pus and disintegrating blood-clot, and so also were both ophthalmic veins. The presence of pus was verified by microscopic examination. Before I proceed to the discussion of these cases, I may say that I doubt very much if the appearance noticed by Dr Lawrence is the same, or has had the same origin, as that seen in my cases. My reason for so thinking is, that he describes the appearance as erysipelatous, and says that the substance of the lid was involved. This was not the case in my patients, for the conjunctiva and lachrymal glands only were affected; nor was there any proptosis. In Dr Lawrence's case, the condition of the sinus was not examined. In my cases the lids were not affected, for the anatomical reason that, although the ophthalmic vein joins the cavernous sinus, yet the blood from them would be removed, in case of obstruction of the sinus, by the small rootlets of the ophthalmic vein from the lids which join the angular vein (a branch of the facial) and the frontal veins. The veins from the lachrymal gland join the ophthalmic, which fact accounts for the profuse lachrymation which was present in each of my cases.

The presence of disintegrating thrombi (or, to use Mr Callender's elegant word, *thromballotic* debris) in the sinûs of the brain in cases of surgical fever following injuries and operations, often not connected with the head, has been recorded by many writers; but I have failed to find any record of a symptom by which they may be diagnosed. I use the term *surgical fever* to mean what is generally known as *pyæmia*, not in the somewhat unsatisfactory manner used by Mr Croft, who includes under it all febrile conditions incident to surgical cases other than septicæmic. The very idea conveyed by the meaning of the word *pyæmia* is held to be erroneous by many authorities; and although in one of these cases I satisfied myself that there did occur pus in the sinus (still, however, liable to the fallacy that the corpuscles may have been white cells), every one admits that it is a rare condition. Under the circumstances, I think we had better give up the term *pyæmia* altogether, because at best it names a disease from what can only be a symptom and not the *origo mali;* and we had better recur to the safer term of *surgical fever*, or use, if we must be classical, *septicæmia*, as conveniently vague. A still better term, if I may venture to suggest a new word for our already sufficiently encumbered nomenclature, would be *mudanemia;* μυδαινω includes a meaning more in harmony with our

present humoral pathology than any of the other words with similar significations.

The appearance of the œdema of the conjunctiva in the cases I have narrated was quite peculiar; it was perfectly clear, and unlike the purplish-red œdema of severe cases of catarrhal ophthalmia. In all of the cases it was so extreme that the lids could not be closed, and the epiphora was very troublesome. Vision was not impaired. The symptom is of considerable interest, because it renders the diagnosis of the formation of thrombi quite certain, and it seems to give good ground for a most unfavourable prognosis. It may occur alone, without any but the general symptoms of mudanemia, and the occurrence of so much intracranial mischief does not give rise to such mental disturbance as one might expect when we remember how small is the apparent injury in some cases of tubercular meningitis. Compared with this latter affection, the observed temperature is very low. In tubercular meningitis, I have seen the temperature as high as 105°, although, of course, the occurrence of the disease in a child partly accounts for this. The symptom follows other than head injuries, and that it is an indication of surgical fever is shown by the facts, that in one of the cases commencing secondary abscesses of the lung were found; and that the third case occurred along with other two cases of fatal surgical fever in the same ward of the Clayton Hospital.

ARTICLE VIII.—*Notes on some of the Diseases prevalent in Victoria, Australia.* By W. LINDESAY RICHARDSON, M.D., for six years one of the Physicians to the Ballarat District Hospital.

ONE great peculiarity of Victoria is the diversity of climate obtainable within four degrees of latitude. In the Alpine region of Gipp's Land the winters are severe, and frost and snow not uncommon. At Echuca, on the Murray, in the northern extremity, the temperature is that of Egypt. Rain here is scarce, and periods of twelve and eighteen months have been known to occur with only occasional showers. In the more central parts the year is divided into the wet and dry seasons, which correspond with European ideas of winter and summer. The annual rainfall does not vary materially in the mean of seven years from that of Greenwich, although the quantity is not so equally distributed over the months. The following is the amount that fell at Ballarat, omitting fractions, for seven years, and is extracted from the register kept at the District Survey Office:—In 1860, 32 inches; 1861, 27; 1862, 21; 1863, 31; 1864, 24; 1865, 21; and 1866, 23; presenting a mean slightly over 25 inches, while the mean at Greenwich for six years, 1858-62, was 24·48 inches. Now, this question of wet and dry periods has a much greater influence on the habits, health, and diseases of the people than might be at first