apparently too meddlesome treatment has been rewarded by success in a case reported subsequent to this paper, and by two reported cases of diffuse septic peritonitis—both successful—which Mr. Henrotin, of Chicago, treated by enterostomy and drainage.—(*New York Medical Journal*, June 1894.)

HYDATID OF THE FEMUR LEADING TO FRACTURE.—Hydatids are of course met with almost anywhere—but still hydatid of a bone leading to its fracture is, I should think, almost unknown, and full worthy of a record. Hydatid in connection with a bone is itself extremely rare as can be seen from the fact that Dr. Poulton states that during ten years 267 cases of hydatid disease were treated in the wards of the Adelaide Hospital, and only one found affecting the bone. The case at present referred to was that of a labourer aged 21, who had for some weeks been complaining of pains in the right thigh which were regarded as rheumatic. The immediate cause of the fracture was, however, due to his having slipped while walking on the ground; the fall itself would have been quite insufficient to produce fracture in a healthy young man. He was, however, found to have fractured his femur transversely in the middle; eventually good union was obtained, and the length of each limb was nearly the same. A little later, however, the limb was found to be ¾ inch short and no trace of the previous firm union existed—the next event is the formation of an abscess, which on being incised was found to be a hydatid that had suppurated; an incision was now made on the outer side of the thigh and the femur was found to be a mere shell of bone except at its posterior part; large quantities of daughter cysts came away; the whole of the shaft was hollowed out, and the inner surface of the bone rough and uneven.—(*Australian Medical Journal*, April 1894).

THE IMPORTANCE OF COMPLETELY CURING THE INFLAMMATORY AND OBSTRUCTIVE DEPOSIT APT TO REMAIN AFTER EPIDIDYMITIS.—Professor Seeligmann finds that in sterilitas matrimonii 75 p. c. of the cases are due to defects in the male, the chief cause being azoospermia resulting from bilateral epididymitis of gonorrhœal origin. To prevent this result every case of gonorrhœal epididymitis should be treated with methodical massage and the application of ichthyol and permanent compression. The testes should first be gently kneaded and rubbed with the finger points, and this action then applied to the epididymis, and finally to the funiculus seminalis. Special attention must be paid to the cauda epididymis, as at this point the vas deferens makes a very sharp bend, and the hyperplastic connective tissue resulting from the inflammatory process is here most abundant. Ichthyol should be freely applied to the scrotum every other day in the form of a five to ten per cent. lanoline ointment. For compression a Langlebert's suspensorium, made of some impermeable substance, should be worn. The sides of the scrotal portion should be partially made of elastic material so as to produce a gentle pressure on the testes, which should be protected by a thin layer of wadding. By this means it is claimed that even old cases of epididymitis may be treated with good hope of restitution of function.—(*Provincial Medical Journal*, February 1894.)

PERFORATION IN TYPHOID TREATED BY EXCISING THE PERFORATION, AND WASHING OUT THE PERITONEAL CAVITY.—Dr. Cayley and Mr. Bland Sutton gave an interesting account of such a case at a recent meeting of the Clinical Society of London. Perforation occurred on the 24th day, and it was considered a specially favourable case for this treatment, because the case was that of a young man, the type of the fever had been mild, and before the perforation the patient's strength had been well maintained. The absence throughout of diarrhœa or other intestinal symptom suggested that the ulceration was slight in amount, and probably situated rather high up in the ileum, where it would be more easily accessible. Moreover, as this was about the 24th day of the illness, there was reasonable hope that the fever was drawing to a close. These points are given in detail because it is considered by the authors of the paper that only under such favourable circumstances would the operation be justifiable. The perforation was easily found in the centre of an oval ulcer, which was excised, and the cut edges of the mucous membrane were drawn into apposition by a continuous silk suture, and then the serous surfaces were brought together by eleven Lembert sutures. The operation lasted nearly an hour; the case rallied for a few days, but ultimately passed into a typhoid state and died. Some leakage of gas had taken place, due to the sloughing of a stitch exactly in the middle of the incision, but fluid could readily be made to gurgle through this part of the gut without leading to leakage. As Mr. Bland Sutton admitted at the end of the paper, it would undoubtedly be best in all such cases to merely cleanse the peritoneal cavity and then attach the perforated bowel to the abdominal incision, and leave a fistula which could be subsequently dealt with; this would considerably shorten the operation and so minimise shock, while no untoward accidents from a sutured gut within the closed abdomen could occur.—(*Medical Press and Circular*, March 1894.)

H. W. PILGRIM, M.B., LOND.

OPHTHALMOLOGY.

"A CASE OF RETINITIS PIGMENTOSA, WITH EXTREME CONTRACTION OF THE VISUAL FIELDS AND WITHOUT NIGHT-BLINDNESS."—Dr. F. W. Marlow, of Syracuse, N.Y., relates the case of a