and during the annual course of musketry in March 1890, the men whose cases are related below were sent up for examination as being unable to see the bull's eye on the target.

The following is a fair sample of the sort of history they all gave:—

At Mahline, in 1888, had had fever, and was in hospital for some six weeks or so,—was then sent to Ye-U and Hluttaik, where he had had fever with diarrhœa and swelling of the legs. It was after this fever that he noticed dimness of vision with pain, accompanied by pricking and burning in the eyes. Objects appeared as if seen through wool, and things at a distance could not be distinguished; thus he could see a figure walking, but could not say whether it was a man or woman; or again, trees were seen as blotches only: the leaves could not be made out.

On individual examination the following was found:—

Sepoy No. 1261, *Syed Wazir*, had been troubled with dimness of vision for nearly two years.

R. V.=$\frac{6}{20}$; L. V.=$\frac{8}{20}$.

Field of vision slightly contracted in both eyes.

Ophthalmoscopic examination.—Right eye, reflex redder than normal from absence of hexagonal pigment. Disc bluish-white and distinctly cupped, margin regular, slight scleral ring on nasal side. Arteries very small, veins large and with woolly outlines. Left eye, disc smaller than in right eye and not cupped, though white. Vessels same as other eye. Many choroidal vessels are seen and pigment almost absent.

This man went up before a Medical Invaliding Board and was pensioned the following year.

Sepoy No. 1501, *Shaikh Husani*, has been dim-sighted for 18 months.

R. V.=$\frac{6}{20}$; L. V.=$\frac{5}{20}$.

Field of vision not affected.

Ophthalmoscopic examination.—Right eye, disc pale, edge distinct all round, small cup in centre. Arteries small and pale, veins full with pulsation in one, increased on pressure. Left eye, disc pale with deep cup in centre, over the edge of which the vessels are seen to bend. Margin of disc clear, except where the vessels pass over the edge, where it is blurred. Arteries small, veins normal in size but blurred in outline, as if from exudation spread over the fundus.

This man was also invalided the following year.

Sepoy No. 744, *Narrainsawmy*, dim-sighted for 18 months. Field of vision slightly contracted in both eyes.

R. V.=$\frac{6}{20}$; L. V.=$\frac{9}{20}$.

Ophthalmoscopic examination.—Right eye, disc white, with extensive cupping. Edge clear, except where vessels pass out, where it is blurred. Arteries mere threads, veins normal in size. Left eye, disc not so white as right, cupped in centre where it is palest, edge clear. Arteries more thread-like than normal, veins full.

This man did not improve under treatment, and was pensioned two years subsequently.

Sepoy No. 776, *Apalsawmy*, had been dim-sighted for only 6 months.

Field of vision contracted in both eyes.

R. V.=$\frac{15}{20}$; L. V.=$\frac{12}{20}$.

Ophthalmoscopic examination.—Right eye, reflex whiter than usual. Disc whitish, especially at the nasal side, no cupping, edges clear. Arteries small and with no reflex, veins normal in size but with woolly outlines. A few choroidal vessels to be seen. Left eye, reflex not so white; disc has a rosy tinge, but appears paler than normal, though not cupped. Arteries about normal and with linear reflex; outline of veins woolly. A few choroidal vessels to be seen.

This man gradually got better under treatment, and is now, for all practical purposes, cured, his eyesight being sufficient to enable him to fire his annual course.

As far as is known he is the only one of the four who recovered, and probably owes his recovery to having come under treatment at a comparatively early period, before the inflammation had gone on to complete atrophy of the nerve.

This inflammation of the optic nerve and retina is certainly a thing to be borne in mind when serving with troops in a malarious country, so that all men complaining of dimness of vision may be at once examined and put on antiperiodic remedies if any suspicion of malarial poisoning exists.

Malaria as a cause of neuroretinitis is a subject only incidentally referred to in most textbooks, though more fully dealt with by Macnamara in his book on the Diseases of the Eye. See also, on this subject, papers by him in the *British Medical Journal* of 8th March and 3rd May 1890, where several recent cases are recorded, and where he recommends full doses of quinine and arsenic, with strychnine, and, of course, change from the malarious locality.

It is a matter full of importance to the Army Surgeon and well deserving of further study.

CASES FROM CHINGLEPUT DISTRICT.

By Surg.-Major W. F. Thomas, M.R.C.S.,
District Surgeon, Chingleput.

I.—Case of Compound Dislocation of Sternal End of Left Clavicle—Removal of Clavicle—Recovery.

Poonusami, aged 13 years, school-boy, a resident of Madurantakam, Chingleput District, was admitted into the Chingleput Civil Hospital, on the morning of 1st August 1892, with a Compound dislocation of sternal end of left clavicle.

Clinical History.—On 21st June 1892 the lad fell from a tree, after which a swelling with "something white protruding" appeared on

inner side of left clavicular line. The mother of the lad applied some external application, and then thought nothing more of the accident. But this swelling continued to increase in size until it attained the size of a cricket ball; and on the morning of 1st July the swelling burst, discharging a thick offensive purulent fluid. About the 7th of July another swelling appeared at the external end of left clavicle, and this swelling continued to increase in size, and on the 13th July burst, discharging very offensive purulent fluid. A large quantity of pus was constantly draining away from both openings, and the lad was daily growing weaker. From date of accident to date of admission into hospital the lad had "Fever" every day.

Condition on Admission.—He was an emaciated, phthisical lad; 4ft. in height, 20 inches round the chest over nipple line, and weighing 50lbs. Two small openings were noticed in the left clavicular line,—one at the sternal and one at the acromial end; both openings discharging freely offensive purulent fluid. The sternal end of left clavicle was protruding for nearly ½ an inch from the inner opening. There was noticed a fulness and brawny induration extending along the anterior aspect of the left acromio—clavicular synchondrosis and left shoulder. The protruding sternal end of clavicle was partially necrosed. On manipulation the whole clavicle felt loose. There was a slight drooping of the left shoulder. The general aspect and condition of the little patient indicated great pain and suffering. The features were very pinched, and the boy constantly supported the left upper extremity against his chest.

The skin was cold and covered with a cold, clammy sweat. Temperature 97 F. The pulse was small, feeble, regular, 60. The respirations were slow, 14, laboured and heaving. On making a very careful physical examination nothing abnormal was detected in the thoracic or abdominal organs. The mouth and tongue were dry. The tongue clean. No appetite, suffered much from thirst. Bowels move regularly once daily. Slept well. Genito-urinary system normal. No sugar or albumen present in urine.

Treatment.—With all due antiseptic precautions the diseased part was examined; and feeling quite certain that the left clavicle was quite unattached and loose, with very gentle traction by means of dressing forceps, the whole bone was extracted from the inner opening. On removal of the bone there was a great outflow of pus. The pyogenic canal was washed out with corrosive sublimate lotion (1 in 2,000); two small drainage tubes were inserted—one through each opening; iodoform dusting, antiseptic absorbent wool, and a single spica bandage were applied over the parts. Bark and ammonia mixture.

Diet.—Milk, eggs, rice gruel; and mutton broth ℥vi—daily.

Comments.—From date of admission to 15th August the temperature kept nearly normal throughout; but from 16th to 28th there was a daily evening rise of temperature to the extent of one to two degrees above normal, falling to normal each morning. During this fever stage 2 grs. of quin. sulph. three times a day were administered in addition to the treatment stated above. There was very steady daily progress towards recovery and daily lessening in the discharge of pus. From 29th August to date of discharge from Hospital (23rd September 1892) the temperature kept normal, and there was no discharge of pus. From 29th August the drainage tubes were discontinued, and simple iodoform dusting and bandage applied to the parts; with ammonia and bark mixture three times a day; and ol. myrrhuæ ℥ii. *b. d.* Both ends of the clavicle are necrosed; the acromial end presenting the appearance as if "worm-eaten," and far more necrosed than the sternal end.

The lad was discharged from Hospital on 23rd September 1892, perfectly well. He had gained flesh; his chest measurement had increased from 20 to 22½ inches, and his weight from 50lbs. to 66lbs. Looking at the lad no one could detect anything amiss with him. I kept him in Chingleput for a few days longer, and was pleased with his condition on his returning to his own native town. The movements of the left upper extremity were perfectly free; there was no drooping of the left shoulder, nor any difference noticed in the two shoulders. One would have expected that the clavicular attachments of the trapezius and deltoid muscles would have seriously interfered with the symmetry of the left shoulder.

I have thought this case worthy of record, as removal of the clavicle is of rare occurrence; as a case of compound dislocation of clavicle, as far as known to me, is not on record. I know of some instances where the clavicle has been removed for necrosis, and where the bone was regenerated from the periosteum left behind. But I regret that, from the nature of the case, I was not able to leave periosteum *in situ*.

II.—Thrombosis of Right and Left Internal Saphenous Veins.

No. 2930, Pt. V, 17th Regt. M. I., age 25, service 6 years, was admitted into Hospital for Thrombosis of internal saphenous veins. The man was a Hindoo by race; married one year previous to admission, habits temperate, no history of hereditary tendency to any disease; and general state of health of his family was good. Had one admission for primary syphilis; and a few admissions for ague and anæmia. The disease was said to have commenced suddenly a few days before admission, with œdema and pain in the limbs. On admission (14th September 1885,) the

following symptoms were noted:—The aspect and condition of the patient indicated pain, and there was a feeling of general malaise. The patient was very anæmic. Skin cold and clammy, temperature being normal. The pulse was small, feeble, irregular, 70. Respirations, 16, shallow, heaving. The heart sounds and apex beat were weak. Complained of pain about the cardiac region; and there was present cardiac dyspnœa, but no organic mischief of any kind present. Digestive organs and functions healthy. There was an anxious look about the patient, and he was very restless. Both lower extremities were cold and œdematous. The internal saphenous veins were enlarged, thickened, hard, and tender to the touch, and at the seat of the valves distinct prominences were seen. Both legs were stiff and swollen, and the patient complained of sharp, shooting, darting pains along the course of the internal saphenous veins. No sugar or albumen in the urine.

Treatment.—Belladonna pigment painted along the course of the internal saphenous veins; the patient kept strictly in bed; hot formentations of poppy-heads applied; emplast. Belladon. 4″×4″ applied to the cardiac region; and a mixture was given containing digitalis, nitrous ether and ammonia.

The patient shewed steady signs of improvement up to 23rd October, nearly a month and a half after admission, on which date the morning body temperature rose one degree; the pulse was feeble, quick, 120. There was urgent cardiac dyspnœa; and cardiac action was tumultuous. The left leg was tense and shining, and there was a slight discolouration from knee to ankle. Diffusible stimulants were administered, and the local treatment continued. The patient remained in this condition till the 25th October, when there was very urgent cardiac dyspnœa, and at 11-30 A.M. he suddenly died.

Post-mortem was not admitted by the relatives.

(*To be continued.*)

CASE OF URETHRAL CALCULUS.

By Surgeon-Major W. H. Henderson, F.R.C.S.I., *Civil Surgeon, Ahmednagar.*

Ramchandra Gopal, Hindoo, a Government servant, was admitted into the Ripon Hospital, Ahmednagar, on the 29th of November, suffering from an enlargement of the penis, a congenital phimosis, and great difficulty in making water. He stated that from his youth the phimosis had given him considerable trouble, and that the flow of urine had always to some extent been interfered with by it. He enjoyed good health up to about a year ago. About ten years before, as far as he can recollect, he first noticed a hard lump at the end of the penis, which was moveable and painful to the touch, but which did not give him much trouble. As time went on the lump steadily increased in size, and passing his urine became more difficult. He attributed this to the phimosis, the opening of the prepuce having decreased in size. His discomfort on account of the swelling and difficulty in making water varied, and for weeks he would be almost free from pain and pass water without serious inconvenience.

About a year ago matters changed materially for the worse. The enlargement of the penis rapidly increased, the pain became very severe, and urine was passed drop by drop. His health became so seriously affected that his friends at last persuaded him to come to Ahmednagar for treatment. When I saw him the glans penis appeared greatly enlarged, and was of stony hardness to the touch; the prepuce was tightly stretched over it, and the opening into it so small that a small-sized probe could with difficulty be introduced.

After some difficulty he was persuaded to undergo an operation, placed on the table and chloroform administered. An attempt was made to slit up the prepuce, but this was found so tightly adherent that it had to be carefully dissected back. This took some time, and the patient bearing the chloroform badly was removed from the table to his bed. Next day, having applied cocaine freely to the part, an incision was made into the glans at the point where the urine escaped. On doing so the knife grated against a hard substance, which on enlarging the opening proved to be a calculus. This was extracted after some difficulty and proved to be of a phosphatic character, weighing 4½ drachms, measuring 1¾ inch in length, and 3 inches in circumference in the centre, tapering off to a point at each end.

It is evident that an attempt had been made, probably ten years ago, to expel a small calculus which had been lodged in the fossa navicularis, its further egress being obstructed by the congenital phimosis. Here it remained gradually increasing in size, until the patient was driven by the pain and inconvenience caused by it to seek relief.

I have never before seen so large a calculus in the urethra, nor have I heard of one of such dimensions being actually lodged so long there.

CASES FROM BARISAL MUNICIPAL HOSPITAL.

By Surgn.-Lt.-Col. K. P. Gupta, M.B., F.R.C.S. (Edin.), and D. Ph. (Cantab.)

Trephining.—Hari Charan Jellia was brought to the hospital by the Police on 11th October at 8 A.M. in a comatose condition, bleeding from the nose and breathing stertorously. It was noticed that the right side of his face and left limbs were paralysed, and the right side had strong spasms and convulsions, so much so that the right arm and leg had to be held down or tied to the bed. The history given was that on the previous night the man was struck two or three blows with a *lathi* while lying down. On exam-