

eye is the presence of a pericorneal zone of redness, either partial or complete. In proportion as the inflammation is plastic in character will be the benefit derived. And for its direct influence on the nutrition of the part, the largest amount of the mydriatic does not always give the best result.

It may seem that I have busied myself with the discussion of very small details; but ignorance of details nullifies the value of more pretentious knowledge, and nowhere more frequently than in the application of mydriatics to the eye.

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#### SUPPURATIVE PERITONITIS; OPENING, WASHING, AND SPONGING THE PERITONEUM; RECOVERY.

At the meeting of the Clinical Society of London, on October 28, Mr. Richard Barwell read notes of this case. The man, æt. 42, accustomed to drink a good deal, was admitted into Charing Cross Hospital June 21, 1887. Six days previously he fell and struck the left lower part of the abdomen, but seemed very little hurt. Five days afterwards he, in stooping, felt severe pain in the lower part of the abdomen; he vomited and passed a little very dark-colored urine. (Absence or presence of blood could not be verified.) He went to bed; his abdomen swelled, he passed very little urine; vomited after, and sometimes without, taking food. On admission he was placed in a warm bath; while in it he passed what may, he thinks, have amounted to a wine-glassful of urine. At 2 p.m. Mr. Barwell found him with pinched, anxious countenance, pulse small, hard, and quick, and temperature  $100.4^{\circ}$ , dry skin, tongue somewhat coated, vomiting, abdomen slightly tender, save in left iliac region, much swollen, very tympanitic quite down to the pubes; tapping it produced a peculiar thrill not like that of flatulence. A No. 12 catheter brought away no urine, even though pressed far back, but the instrument when withdrawn was full of urine deeply stained with blood. June 25. On three occasions 10 ounces of urine had been passed, at first with blood, the last sample free of blood, but slightly albuminous, specific gravity 1022; temperature  $89^{\circ}$ ; pulse 130; abdomen more distended. It being evident that the man had a bad type of acute peritonitis, Mr. Barwell opened the abdomen in the middle line below the umbilicus. A large quantity of gas, not of feculent odor, escaped. No rupture of any viscus was found, but in its lower part the peritoneum contained a quantity of thick pus. There were no adhesions; parts of the intestines were congested, and the membrane was somewhat thickened. Three sponges passed into the lower part of the cavity were withdrawn covered with tenacious flocculent pus. A smooth-nozzled glass funnel was then deeply introduced, and the part of the cavity washed out with 10 pints of distilled water, temperature  $99^{\circ}$ , bringing away quantities of pus and flocculi. After sponging, a second smaller

washing and sponging was directed to the upper part. The abdomen was then sewn close without any drain. The whole operation, including the anæsthetic and dressing, lasted an hour. June 26. During the night and day the patient frequently vomited a brown fluid with darker concretæ; pulse rather fuller, 110; abdomen scarcely distended, and tender only in immediate neighborhood of the wound. He was lying flat, save for a small pillow under the knees; said he was quite well, and wanted to go home. July 28. The vomiting slowly decreased during the night; the bowels acted rather copiously four times. The vomiting ceased and all symptoms passed rapidly away. The rest of the history was that of rapid convalescence, the man being very importunate in requesting to be discharged. In his remarks Mr. Barwell, referring to a paper by Mr. Hancock, claimed for Charing Cross Hospital the first conception of the idea of opening the peritoneum for acute peritonitis (*Lancet*, 1848, "Meeting of Medical Society"). He also pointed out that this operation had been performed fourteen times, though the operator had not always known what was the precise nature of the case and the circumstances had been very various, ulcers or rupture of some part of the intestinal tract, or of an ovarian cyst. He emphasized the impossibility of draining the lower part of the peritoneum through a wound in the front of the abdomen, and advised that no drainage-tube should be inserted immediately after operation, but that if distention recurred to remove the lower stiches and permit escape. The presence of a tube, which could not in that position act as a drain, might be injurious rather than beneficial. In the female, drainage *per vaginam* would probably be the most valuable treatment as the best wash, since disinfectant lotions, strong enough to act as germicides, could not be brought into contact with any large surface of the peritoneum without injurious effects, local, systemic, or both.—*British Medical Journal*, November 5, 1887.

#### THE TREATMENT OF OPHTHALMIA NEONATORUM.

Mules, of the Manchester Eye Hospital, in a Prize Essay published in the *Medical Chronicle* for January, 1888, describes the following treatment:

The mother or nurse should first wash the eyes in warm water to remove the secretion and free the lids. The surgeon should be seated in a convenient chair, with a folded towel across his knees and with medical appliances within reach of his hand. These appliances are: (1) A plentiful supply of pieces of clean rag; (2) solutions of argenti. nit., 5 grs. to oz., and 10 grs. to 1 oz.; (3) vessel of clean water; (4) two camel's-hair pencils to apply the solutions and wash the excess of fluid away; (5) a bottle of eserine, 5 grs. to 1 oz., and dropper; (6) lid elevators. He then receives the head between his knees, yet