

to inspect the fracture or remove the dressing! Then you may ask when to use plaster—only when all swelling has subsided, absorption of extravasated blood taken place, and you wish to give your patient his freedom during convalescence. Practically then, use plaster-of-Paris dressing after the bone has united and you wish to protect the point of injury from possible results of attempting to move about. Another point is, under no circumstances use this dressing without plenty of cotton or other padding next the skin. It is never proper to use plaster-of-Paris without this plentiful layer of cotton.

There are many forms of retentive dressings which come and have a trial and are forgotten. Many of them, like wigan, silicate, starch, wire-cloth and others have advocates, and all are useful, but useful only when convenient. We have these things in mind only to be applied when they are easily reached. But under no circumstances can all fractures be dressed with one form of dressing or one kind of splint. You can find bark or a limb of a tree in the forest, that will make a splint to fit the case in hand, and I believe that every surgeon ought to be able to dress his case of fracture with what he can find on the spot. If he expects to manage such cases successfully, he should have mechanical ingenuity to adapt conditions to his needs and not be helpless because he may not have his favorite dressings with him. But these are all to be considered as temporary and applied to meet the needs of transportation, and in all cases when the patient reaches his home or a permanent residence he should have a non-constrictive dressing and be made comfortable.

I can give positive results from actual experience in many cases with this principle applied, but one of each kind will be more than enough.

CASE 1.—A railroad brakeman had his leg broken by a derailment, a car crushing him. He received an immediate dressing of plaster-of-Paris, and within a short time, from constriction of the dressings, the pain became unbearable and, when first seen by me, the dressing had been cut, the leg was covered with large blisters, was very much swollen and still painful. This visit was at night, but by making a sketch and giving an ordinarily bright young man directions, he brought a splint—Hodgen's—ready for use in less than an hour. After suspending the leg and adjusting the short strips of bandage there was no further trouble, and healing was uneventful.

CASE 2.—An impacted fracture of the neck of the femur was treated with a similar splint and sand-bags, with a good recovery, a useful limb, and no unpleasant symptoms. This patient was a woman, very much emaciated and neurasthenic. She now walks with scarcely a perceptible limp.

CASE 3.—A crushing injury of the leg was caused by a heavy log striking it, in a man of 55, of phlegmatic temperament. He was dressed in a fracture-box at first, applied very loosely, but swelling occurred to such an extent that I was obliged to suspend the leg and remove every form of constriction. Enormously large blisters, filled with bloody serum, extended from the knee to the ankle, the foot was cold, and every appearance of gangrene occurred, yet by suspension and non-constriction I succeeded in getting a result which, being slow—about two months—was as perfect as if in a younger man with a better constitution. In this case there was no possibility of saving limb or life with any form of constriction.

CASE 4.—This was similar to Case 3 in every way, as to constitution and conditions of the system. The injury was a fracture of the malleoli with dislocation. Four hours after the injury I found the patient as free from pain as if he had sustained no hurt; he had slept and was comfortable, and yet there was complete displacement with laceration of all structures at the ankle-joint, sharp fragments of bone pressing dangerously on the skin to such an extent that perforation was almost complete. There was no sensation on reduction. Blisters similar to those in Case 3 formed over the injured parts. Similar open treatment was given, with good recovery in a reasonable time.

CASE 5.—This was a fracture of the middle third of the femur, with contusions of various parts of the body. The patient had been struck by an engine on a crossing. Suspension, non-constriction and healing without shortening was secured.

In some of these cases any form of constriction would have produced disaster, and if we get good results in our worst cases with such dressings, how much better must be the healing powers in the ordinary case. How much anxiety is saved by the ready inspection, ease and comfort and gain in time to the patient!

ACUTE GLAUCOMA DEVELOPING IN A CATARACTOUS EYE, AFTER CATARACT EXTRACTION IN OTHER EYE. IRIDECTOMY AND CURE.

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Among the more serious affections of the eye, there is not one which demands such prompt and proper attention as that known as acute glaucoma, or the so-called green cataract of the early writers. And while it is the usual and every-day facts and phases of a subject which should demand our most considerate attention, yet it is likewise true that we should be cognizant of the unusual and atypical, in order that our mission may be best fulfilled. Such is the excuse for that which is to follow.

Glaucoma is said to be secondary when it occurs as a result of some previously existing disease of the eye; and complicating, when it occurs in the presence of another eye affection, but without apparent etiologic relation to the same. The case in point probably belongs to the latter class, though the distinction is largely a matter of individual opinion.

Exclusive of nationality, the factors which predispose are old age, with its accompanying changes, hypermetropia, and a small cornea. Of these, the first and last were present.

Various theories have been advanced as to the mechanism of the disease, most of which are no longer tenable since the demonstration of the nutrition processes and the path of the circulation of fluids in the normal eye.¹

A general review of the late literature on the subject leads one to accept these facts: 1. That glaucoma is due to a disturbance of excretion rather than an increase of secretion. 2. That this excretory blockade is accomplished by an abnormally swollen ciliary body pressing the iris-base against the periphery of the cornea, to which it soon becomes adherent, and in this manner causing a retention of fluid by closing the filtration angle. 3. That the only reliable and safe method of treatment is broad peripheral iridectomy, done early and under general anesthesia.

1. De Schweinitz: p. 376.

Noyes² says that iridectomy performed in one eye for the relief of glaucoma may occasion the outbreak of acute glaucoma in the other and previously healthy eye, he having seen one instance of this. It is to be presumed that the simple cataract extraction, in a case without evidence of glaucoma, would exert a similar influence, even though the iris was not cut. This fact must be explained by reflex ciliary irritation.

Numerous cases have been reported in which glaucoma followed cataract extraction—either simple or with iridectomy—in the eye operated on, having usually been caused by peripheral adhesions of the iris. Pagenstecher³ divides these cases into two groups: 1, those in which the process is a direct result of the cataract operation; and 2, those in which it appears after the eye has regained its function. He further says that it occurs more often after the simple than the combined operation, and that it may follow discission.

Dabney⁴ reports a case in which the instillation of two drops of a 1 per cent. solution of atropia into the conjunctival sac of a man of 22 years, suffering from a purulent conjunctivitis, induced symptoms of acute glaucoma. In ten days vision had returned to normal. It is interesting to note that the patient's mother had glaucoma.

Treacher Collins⁵ studied two cases of congenital and one of traumatic aniridia with glaucoma, in each of which the filtration angle was blocked—in the congenital cases by a stump of undeveloped iris, externally invisible; and in the traumatic case by a pulling forward of the ciliary processes. So much for these unusual traits of glaucoma; but as to the case in point, I have as yet seen no instance mentioned of acute glaucoma in a cataractous eye, following simple cataract extraction of the other eye. Such was the case under consideration. The clinical history is as follows:

Mrs. H. D., an American, 80 years of age, and housewife by occupation, was first seen on Aug. 8, 1900, when she was found to have binocular senile cataract. She gave a history of having lost all vision in the left eye twelve years before, and that in the right eye five months before. She had good light perception over the normal visual field in each eye. On August 13 I removed the lens from the left eye, making a 3 mm. flap, and no sooner was the corneal section completed than the lens appeared in the wound and had only to be lifted out. This occurred, as is sometimes the case, without any pressure being exerted and without capsulotomy, the lens escaping intact—due, no doubt, to the over-ripe and atrophied condition of the lens, and to lack of adhesion of the posterior capsule to the lenticular fossa. By this result we had no fear of cortical remnants, nor of capsular cataract. The usual after-treatment was adopted and recovery was uninterrupted.

On October 5, or fifty-three days after the cataract extraction in the left eye, acute glaucoma developed in the right, with premonitory symptoms for two weeks previously. Tension was increased to +2 or +3, pain severe, paroxysmal in character and worse at night. The cornea was hazy and asthetic; the iris discolored, dilated to a mere ring, and fixed.

The object of treatment, from the beginning, was not necessarily to save vision, but to give relief in such a manner as to make our patient comfortable for her few remaining years.

After temporizing with instillations of eserine, alone and with cocaine, warm boric acid solution as a collyrium, hot compresses, and repeated paracentesis of the anterior chamber through the base of a large central corneal ulcer which had formed, a broad peripheral iridectomy was made on November 11, under cocaine anesthesia—which proved rather unsatisfactory, owing to hardness of the eyeball.

The patient complained of some indefinite pain for four or five days following, during which time the tension was slightly plus. Since then she has been entirely free from pain, with tension about normal. She is wearing a +11.00 sph. over the left eye, which gives a vision of 20/200.

SITOPHOBIA OF ENTERIC ORIGIN.*

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Sitophobia, meaning fear of food, is a condition which may last a long period of time and, if not successfully treated, may endanger life. It is therefore natural that this subject should command the full attention of the practitioner.

When I first used the term sitophobia I was not aware that Guislain¹ had already employed the same word to designate the refusal of food which is so often encountered in cases of melancholia and in the insane. For this condition, however, the word introduced by Sollier², namely, "sitieirgy," meaning refusing food, seems to be more appropriate. For, in the insane, the patients do not want to eat, not because they are afraid of the food, but for different reasons; either they are in a state of depression, unwilling to do anything, even eating, or they have suicidal ideas, or they have illusions that the food may be poisoned, etc. I may be, therefore, permitted to reserve the term sitophobia for those conditions only in which there is distinct fear of taking food on account of resultant bad consequences. Sitophobia in this sense has nothing to do with the insane and is found in mentally perfectly sound people.

In my paper, "The Diet of Dyspeptics,"³ I have already alluded to the importance of sitophobia and its management.

While, however, in the above article sitophobia is spoken of as occurring in cases of disorders of the stomach, principally those accompanied by pains, of late I had the opportunity to observe the same condition in persons who had no gastric symptoms whatever and in whom "the fear of food" was due to some intestinal difficulty. I shall, therefore, in this paper speak of the latter group of cases, or of "stopophobia of enteric origin."

A good illustration of the importance of this condition will be found in the following case, which I beg to describe:

William H., 28 years old, bookkeeper, had always been well up to two and a quarter years ago. At that time he became constipated, which condition gradually grew worse, occasionally alternating with diarrhea. Off and on, mucus was observed in the stool. His appetite was good, but he suffered at times from headaches and disturbed sleep. Patient consulted me for the first time in March, 1900, and was given magnes. usta in conjunction with ferratin and olive oil enemas, after which he improved for awhile. He went to the country, where his condition again became worse. On his return to the city, in August, patient was given podophyllin pills, which, however, did him no good. He then went to another physician, who ordered some medicine and injections of water.

These remedies not proving of benefit, patient again resorted to the podophyllin pills and injections every day, using both these means from September, 1900, to March, 1901. Often he would go without a movement of the bowels for seven to ten days. During all this time he ate much less than he was previously accustomed to, because he was afraid "that he would get entanglement of the bowel." His weight steadily grew

* Read before the New York Academy of Medicine, May 16, 1901.

1. Guislain: *Eulenberg's Realencyclopädie der Medizin*, 1887, Bd. xii, p. 696.

2. Sollier: *Revue de Medecine*, aout, 1891.

3. Max Einhorn: *Medical Record*, Jan. 1, 1898.

2. Diseases of the Eye, p. 566.

3. Klin. Monatsbl. f. Augenh., May, 1895.

4. Am. Prac. and News, Feb. 16, 1889.

5. Ophthalmic Review, April, 1891.