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Corporal B.'s bayonet scabbard presented a curious appearance. There was a small, clean-cut hole in the back of the metal tip of the scabbard about two inches above the extremity (fig. 1, a). Two holes were found in front, both of irregular outline, the larger on the outer side of the scabbard-tip (fig. 2, a), and the smaller on the inner side (fig. 2, b), adjacent to the man's thigh. The point of the bayonet had a nickel mark on it, corresponding in position to the hole at the back of the scabbard. Thus the bullet had entered the back of the scabbard and been split on the point of the bayonet into two portions. One of these entered Corporal B.'s thigh, and the other flew off at an angle of about 120°, passing dangerously near the head of an officer standing some way to the left of the firing line. A portion of the nickel casing of a bullet was subsequently removed from Corporal B.'s thigh at the Military Hospital, Derby.

TWO CASES FROM THE EYE WARD OF THE ROYAL HERBERT HOSPITAL, WOOLWICH.

By Major H. V. Prynne.
Royal Army Medical Corps.

Case 1.—Gunner G. W., aged 19, service five months. Admitted September 29th, 1903, complaining of complete loss of sight in right eye. The disability was stated to have developed in the course of twenty-four hours, three days previous to admission.

Present Condition.—Ptosis of right upper lid, movements of eyelid on left side normal. Muscular movements of both eyeballs normal. Right pupil somewhat dilated, insensitive to light, not reacting to accommodation, but active upon consensual stimulation. Pain was said to be present on right side of face, but no definite anaesthesia existed. Patient stated he had suffered from "sore throat" three weeks before admission. Palate reflex normal, and knee-jerks brisk. Vision of right eye entirely absent, and this confirmed by prism test. Vision of left eye 1/6.

Ophthalmoscope.—Right pupil fixed and insensitive. Retinal veins of both eyes enlarged and tortuous, especially marked in the case of left eye. On October 4th, 1903, patient began to complain of vertical headache, paroxysmal in character.

On October 7th, 1903, atropine was instilled into left eye, and the refraction estimated.

On October 10th, 1903, patient complained that the sight of left eye had failed completely since the previous evening. Vision of left eye was found to be nil, and the pupil dilated and insensitive to light. The fundus conditions in the two eyes appeared unchanged. Headache was now frontal in position, fairly continuous, and kept him awake at night, and orbital pain was also present. Patchy and transient anaesthesia and
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hyperæsthesia over body and face, with delayed sensation in feet, exaggerated knee-jerks, normal plantar reflex, and absence of ankle clonus were noted.

On October 12th, 1903, slight paresis of right internal rectus was present, and patient commenced to suffer from slight attacks of epistaxis. No vomiting occurred, and the urine contained neither albumen nor sugar. A soft growth was felt in the naso-pharynx.

On October 24th, 1903, the condition had not markedly altered, except that the pupils were slightly smaller, and the edges of each optic disc blurred and indistinct. The pain in face was more constantly referred to the infra-orbital region, where sensation was deficient.

On October 28th, 1903, headache, with pain in eyes and face, were the main symptoms, and there was a patch of permanent anaesthesia by right side of nose and upper lip. It was now noticed that patient had developed seven small, hard swellings, subcutaneous and freely movable. These swellings gradually became congested on the surface, and came to resemble naevoid growths. One growth was situated on the right side of abdomen, about three inches from middle line; one over sixth left rib; one over sternal end of right clavicle; one over left back near vertebral column, opposite twelfth dorsal spine; one over vertebral end of spine of left scapula; one over left supra-spinous fossa, and one one and a half inches below centre of left iliac crest.

On October 31st, 1903, some prominence of right eye was noted. Lungs and liver appeared normal.

On November 4th, 1903, a posterior rhinoscopy was made, and showed a soft vascular growth involving the basi-sphenoid and posterior end of vomer, and projecting into right nostril.

On November 9th, 1903, one swelling was found to have increased from six-eighths of an inch to one inch in diameter.

Since October 28th, 1903, all the swellings were marked on the surface by bluish discolouration. The prominence of right eye was fairly well marked.

The case had been repeatedly seen throughout by Lieutenant-Colonel Whitehead and Lieutenant-Colonel Hickson, and a diagnosis of malignant new growth was accordingly made.

The boy's father was informed, and by special sanction the boy was allowed to be taken to his own home. The further notes of the case were furnished me by Dr. Walter Groome, of Lewisham, who also gave me a specimen of the growth. His condition grew worse with the extension of the neoplasm. The right eye was nearly protruded from the orbit, and the spread of the growth down the pharynx interfered with deglutition and speech. He died on December 9th, 1903, and the post-mortem examination revealed an extensive growth from the basi-sphenoid, which had entered the cranium by the sphenoidal fissure, and also passed...
forward into the orbit. The sudden onset was due in each case to haemorrhage from the growth.

Mr. N. Bishop Harman, of Middlesex Hospital, kindly cut sections of the growth, and reports it to be a small, round-celled sarcoma with many spaces, thin walled blood-vessels, and haemorrhages. It is of a most malignant variety, as in this case death was caused in ten weeks from the onset of symptoms.

CASE 2.—Dr. H., age 33, service twelve years and six months. Admitted November 23rd, 1903, complaining of dimness of vision, especially at night. Right vision $\frac{1}{2}$, left vision $\frac{1}{3}$. Hm. in both eyes $\cdot 5$. Vision not improved by glasses.

Fundi.—In each eye showed a general dull reflex, and appeared darker than consistent with his colouring. One or two spots of peripheral pigmentation. Discs looked whiter than normal by contrast. Refractive error very slight.

On December 12th, 1903, patient was noticed to have a few petechial spots on chest; the gums were spongy, and patient stated he had eaten no vegetables for two and a-half years. He was ordered vegetables and lime-juice, and chloride of calcium was given internally.

On January 2nd, 1904, right vision $= \frac{3}{4}$, left vision $\frac{1}{3}$; dimness of vision at night had quite disappeared, and patient was discharged to duty.

AN UNUSUAL CASE.
BY CAPTAIN W. A. WARD.
Royal Army Medical Corps.

I am induced to record the following case by reason of the unusual nature of the injury and its ultimate recovery.

When doing duty at an Indian Station, in 1903, I was one afternoon taking part in a paper-chase. At the finish, a Major of a British Cavalry Regiment was missing, and someone remembered seeing him fall at a small water jump about three miles away. Another officer went to help him, and found him walking slowly and holding his handkerchief up to his left ear. He stated that he had had a fall and had hurt his ear, and must have been unconscious for a short time, as he remembered nothing about it. He had to walk about four miles to the Station Hospital, where I saw him about two hours after the accident. On removing the handkerchief which, as well as his coat, was covered with blood, I saw that the whole of the external ear was cut off, almost as clean as if cut with a razor, and was merely hanging by a thin thread of skin at the lower angle. The wound was very dirty with bits of grass and mud. The patient was rather blanched and weak from loss of blood. At first I thought it was useless to attempt to sew it on; then I considered that