In mild *ectropion of the lower lid* the same technique holds, except that one applies the point inside the lid and directs it below the tarsal plate down into the connective tissue. The lid can easily be maintained with ordinary forceps. If the condition has been present for a long time and is fairly prominent, it is necessary to excise a longitudinal strip of conjunctiva, usually about one-third the width of the exposed membrane, taking the middle third. The amount taken, however, is largely to be determined by the condition present, and it may be necessary to go higher or lower. The red-hot point is then plunged deeply into the exposed tissue, going below and beyond the tarsal plate, in more places than would be used for entropion, and it is necessary to go beyond the limit of the ectropion. One is not likely to cause the contrary condition, and so it is advisable to be thorough. A drop of argyrol 5% and sterile liquid paraffin is then instilled and the eye kept bandaged for 3 days. The drops are repeated each day, of course. The two edges of the conjunctiva rapidly come together, and there is seldom any break in the continuity after 10 days.

Ectropion of the upper lid is usually more severe and requires to be done thoroughly. The middle third of the conjunctiva is resected along the whole length of lid and the red-hot point is plunged deeply into the connective tissue, to and beyond the tarsal plate, at a sufficient number of places. There is usually quite a lot of haemorrhage after the conjunctiva has been resected, but if the lid is controlled with forceps an assistant with swabs can keep the field fairly clear. The application of the cautery soon stops all bleeding. Argyrol 5% and liquid paraffin are then dropped in, and it is advisable to pass a stitch from upper lid to cheek. This stitch may remain for three days. Thereafter argyrol for a few days more will usually suffice.

Symblepharon is a difficult condition to treat by the usual methods and often recurs. I have only attempted to disengage adhesions, not to cure the condition, when the cornea is invaded. In addition to drops, some cocaine is injected subconjunctivally. The cautery is then applied to divide the adhesions at the most suitable spot, the point being carried down to the sclerotic. Each adhesion is thus treated and the usual argyrol and liquid paraffin instilled. It is seldom that the adhesions reunite.

The treatment of *distichiasis* and *trichiasis* by electrolysis is a long, laborious, and not very successful business. I have been able, with the cautery, to do both lids of an eye at one sitting of about 10 minutes, and the result proved satisfactory. The lids are anaesthetized with novutox and a drop of cocaine placed in the eye. Then a point 5 mm. long and as narrow as possible is used. I always employ the loupe to get a good view of where the point is going. This is used red-hot and pushed down each hair follicle in turn. It must be pushed down its full length and retained for two seconds. The lashes do not grow again and no damage is done to the lid margins.

I have treated a few cases of *congenital ptosis* in children, and if the results have not been brilliant they have at least been satisfactory in leaving the pupil exposed. The principle is to cause the levator to form fresh adhesions to the tarsal plate. The child will require a general anaesthetic, as it will not submit otherwise. A row of six punctures is made just above the tarsal plate, then going into each puncture again, passing the point upwards this time, and in the subcutaneous tissues as far as it will go. The point should be 1½ cm. long. No dressing is necessary, and in fact is inadvisable. I have also dealt with a variety of other conditions, of little consequence, such as warts, which are simply and permanently removed with the cautery.

I hope I do not give the impression of brandishing my cautery at every patient I see. I merely describe it as a very useful procedure in many conditions; it is not generally realized how simple and useful it can be. In my own practice the results are in almost every case superior to those of the scalpel and stitch. I have been practising it now for a number of years.

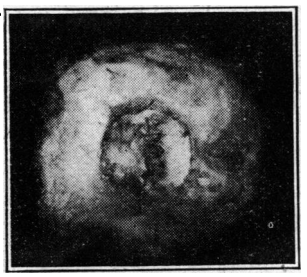
S. Zelman (*Amer. J. med. Sci.*, 1944, **207**, 461) determined blood diastase values in a series of 89 cases of mumps, on admission to hospital and on discharge, with the following results: 73% were above normal on admission and 9% on discharge; 3% were subnormal on admission and 20% on discharge; 15% of this series showed evidence of pancreatitis some time during the course of their illness.

Medical Memoranda

Large Fibroma arising from the Pulmonary Pleura of the Right Lower Lobe

The following case appears to be worthy of publication owing to its rarity and difficulty of diagnosis.

On Aug. 17, 1944, the patient, a man aged 48, consulted his practitioner for pain in the lower part of the right side of his chest on breathing. Examination revealed a dull area at the base of the right lung with weak breath sounds in the area. His temperature was 99.8° F.; he had no cough or sputum. A diagnosis of fluid was made. The basal sedimentation rate was found to be 32 mm. in one hour. His area of dullness increased rapidly, and three days after he was first seen he was screened and a large shadow was observed to move on respiration. It lay in the posterior part of the chest, above the diaphragm. Fluid was also present, and 20 c.cm. was aspirated and sent for pathological examination. It showed



numerous endothelial cells, many of which were undergoing mitosis, and the pathologist suggested that these might be malignant in origin because of this. A tentative diagnosis was made that the tumour might be an endothelioma. Removal of another large collection of fluid caused a great deal of pain, presumably because the tumour was now rubbing against the thoracic wall. It soon ceased as the fluid reaccumulated. This rather tended to support the diagnosis of a malignant tumour.

The man was admitted to the Royal Infirmary, Sheffield, on Sept. 8 and was referred to me for further investigation. A thoracotomy was performed, and on opening the chest a large tumour was found occupying the lower part of the right pleural cavity. It was very nearly spherical, and was lightly attached to the parietal pleura on the one hand by a few adhesions, but arose from the visceral pleura, from which it received its blood supply. Only slight effort served to separate the tumour from the parietal pleura, and it at once fell back into the thoracic cavity. Owing to its size (12 cm. in diameter) it was difficult to manipulate, and it was necessary to resect a portion of a rib in addition to dividing another. On pressing the tumour into the wound from the thorax it shot through the opening in the chest wall and tore itself free from the lung. There was a little bleeding from the area of attachment, which was circular and measured 5 cm. in diameter. The lung was sutured and no further bleeding occurred. The man made an uninterrupted recovery and was able to go home a fortnight later.

The figure is from a photograph of the specimen after removal. The pathological report is that it is a simple fibroma undergoing hyaline degeneration.

I am indebted to Dr. George Herbert of Worksop, who sent the case to me and who also primarily investigated it; and to Dr. L. C. D. Hermitte, of the pathological department, Royal Infirmary, Sheffield, for the pathological notes and photograph.

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An Unusual Case of Ruptured Aortic Aneurysm

Syphilitic aortitis with rupture of a large saccular aneurysm of the abdominal aorta into the stomach is so rarely seen that it was considered justifiable to add the following to the large number of cases of ruptured aortic aneurysm described in the literature.

CLINICAL HISTORY

A civil servant aged 60 was admitted to the Essex County Hospital, Wanstead, on Feb. 16, 1943, complaining of pains in his shoulders, back, and legs; he also had difficulty in swallowing and had lost weight. The pain in his back was of a continuous drawing nature, but he had shooting pains down both legs, accompanied by occasional swelling of his knee- and ankle-joints. He had also noticed some weakness and unsteadiness of his legs. For the past two months he had complained of difficulty in swallowing solids, vomiting almost at once, but he was able to manage fluids and soft foods such as porridge. He lost 2 st. in weight in three months.

On examination he was found to be a very thin, wasted man. His tongue was clean and moist, his throat was normal, and there was no enlargement of his lymphatic glands. No oedema was seen. His pulse was regular, slow, and slightly collapsing. His apex beat was in the midclavicular line and no thrill was palpable in the