

in ten days only slight trace present, less than 1 gr. to ounce. Case iv.—Sugar, 15 grs. to ounce; diet kept unchanged; after six weeks of sodium salicylate treatment sugar only 3 grs. to the ounce; in 20 days later no reaction for sugar by usual methods of testing, but by special methods the slightest trace detected. Case v.—Sugar, 30 grs. to ounce; in sixteen days 6 grs. to ounce. Case vi.—Specific gravity 1033; sugar, considerable amount; in three weeks a trace only; a month later sugar absent. Case vii.—Sugar excretion had been arrested by restricted diet; a few weeks later sugar returned (24 grs. to the ounce); diet kept the same, and sodium salicylate given; in two weeks only slightest trace of sugar present; shortly afterwards it disappeared; six months later sugar again appeared in the urine, but disappeared when sodium salicylate was given. Case viii.—Sugar, 2 grs. to the ounce; reduced to slightest trace (not detected by Fehling's solution) under sodium salicylate. I am prepared to admit that in the Cases ii to viii the results were not quite conclusive, since the patients were not in hospital; but I think it probable that in most, if not in all, of these cases the sodium salicylate had a favourable action.

II. In one case, specific gravity of urine 1033; sugar 20 grs. to the ounce. No treatment previously. Diet was restricted (potatoes, rice, and food containing sugar forbidden, but bread allowed) and sodium salicylate given. The sugar steadily diminished, and in seven weeks had entirely disappeared. The restricted diet has been continued. During the last ten months the urine has been examined every week. Seven months ago the sodium salicylate was discontinued. On three occasions a trace of sugar has returned, but has disappeared when sodium salicylate has been taken.

III. In 5 severe cases of diabetes (the age of the patients being 19, 31, 35, 38, and 40 respectively) there was only a very slight diminution of the sugar excretion, but the symptoms were relieved and the patients gained weight and felt better when taking the drug. In these 5 cases the diet, though restricted, was the same as that taken before the drug was commenced. In 4 cases of medium severity the drug appeared to produce no definite effects, but it was not possible to watch these cases very carefully.

IV. In one case the patient was losing flesh when he commenced the sodium salicylate. After taking it for five days he stated that the diuresis was greater. The drug was at once discontinued, and other treatment given. Death occurred nineteen days later. In another case sodium salicylate was given for seven days, at first in doses of 15 grs. three times, afterwards four times, a day. It was then discontinued. Six days after the drug was discontinued death occurred.

Limited space forbids an account of these cases, but I fail to see any reason for attributing the fatal termination to the administration of the drug for the short periods named. It is not advisable to give sodium salicylate if serious complications are present, or if the patient appears to be losing ground rapidly, because the drug has a bad reputation with many practitioners, and a fatal termination during the salicylate treatment is liable to be attributed to the drug.

I may point out in conclusion that I do not regard sodium salicylate as a specific for diabetes. It does not usually produce any marked diminution of the sugar excretion in the severe forms of the disease; also it has little influence in some of the mild cases. But in certain mild cases of diabetes or persistent glycosuria, as in the first case recorded in this article, it has a decided action in very markedly diminishing the sugar excretion.

The drug is not suitable in all cases of diabetes. It requires to be very carefully watched, and fairly large doses are usually necessary to produce decided results. The natural sodium salicylate is more satisfactory than the common artificial preparation. It is best to commence with 10 grs. three and then four times a day, and to increase slowly up to 15 grs. four or five times a day, watching carefully for any toxic symptoms. I have usually given it in peppermint water, or in equal quantities of peppermint water and ordinary drinking water.

In severe forms of diabetes, though sodium salicylate does not usually cause much change in the sugar excretion, still the patients sometimes gain weight and improve in general condition whilst taking the drug.

AN EASY OPERATION FOR CONGENITAL PTOSIS.

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ANY operation undertaken for the rectification of this abnormality must fulfil two conditions: it must be efficient for the purpose, and it must be so arranged as to leave no cicatrices or scars.

I was recently asked if I could operate on a case of ptosis without leaving much disfigurement, and I employed the following method, which I found easy of execution, and which gave results satisfactory alike to myself and to my young patient's friends:

A horizontal linear incision was made in the eyebrow along its whole extent, this situation being selected because the hairs of the eyebrow afterwards completely hide the scar. No other skin incision is required. With a few strokes of a scalpel the skin was completely separated from the underlying tendon and fascia of the occipito-frontalis muscle; the separation was carried to about a distance of nearly 2 inches above the horizontal wound. In the opposite direction the skin and fascia and portions of the muscular structure were separated from the orbicularis muscle and from the tarsus; the division being carried almost to the free margin of the eyelid.

The next step was to mark out a vertical band of the tendon and fascia of the occipito-frontalis, about three-quarters of an inch broad and 2 inches long. This was dissected up from all underlying structures, and when the dissection was complete its only attachment was to the occipito-frontalis at the part furthest away from the skin incision. The end of the band was drawn down into the upper eyelid, and its margin was secured by catgut sutures as near the margin of the lid as possible. The wound in the skin was closed and covered with a sterilised dressing. The wound healed rapidly and well.

The photographs from which the figures are taken were made about a month after the operation. No. 1 shows the patient after one eyelid had been done. On the right side it

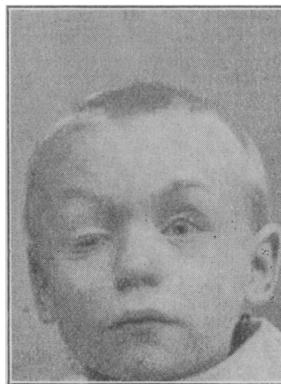


Fig. 1.



Fig. 2.

will be observed that the ptosis is still present, while on the other it has been overcome by the operation. Figure 2 represents the patient with both eyes shut, from which it appears that there was no difficulty in closing the palpebral fissure.

An operation such as the above seems to present many advantages over those commonly employed. Till now the operation which gave the best results in my hands was unquestionably that of Professor Panas, but his operation, although thoroughly removing the ptosis, always left, so far as my operations were concerned, very ugly cicatrices. I have never tried Pagenstecher's modification of Dransart's operation, as it has always seemed to me to be an extremely crude proceeding to trust to inflammation set up by subcutaneous sutures. Moreover, such sutures will not set up the desired inflammatory reaction if they are perfectly sterile when introduced, and surely modern surgical knowledge entirely forbids the introduction of any sutures which are not thoroughly aseptic.

Since performing the operation I have glanced at the literature of ptosis operations, and the only proceeding at all like the one above described which I have been able to find is that of Kunn¹ described by him in 1893. The differences between the method described above and his are very considerable.

REFERENCE.

¹ *Wien. med. Wochenschrift.*

PRESENTATION.—Dr. Livingstone has been presented with a case of instruments bearing the following inscription on a silver plate: "Presented to Dr. Hillhouse Livingstone of Stanhope by the Members of his Ambulance Class at Frosterley, March, 1901."