

Fourteen cases form the entire number mentioned by Hebra, of which one occurred in a woman; and in one instance only was the disease arrested in its course. In the treatment of scrofulous lichen, which appears between the ages of fifteen and twenty-five years, cod-liver has proved an excellent agent, and the only one in Hebra's hands. It is given, however, in half-ounce doses twice a day, a less quantity proving of no benefit. He also advises its external application, and directs the patient in the meantime to wear flannel or woollen clothes. For the relief of the other, or red lichen, Hebra places the most reliance on arsenic. The reader is referred, for further information, to Hebra's article in Virchow's *Handbuch der Speciellen Pathologie und Therapie*, Bd. iii, Lief 2.

[To be continued.]

Original Communications.

PRACTICAL REMARKS ON THE TREATMENT OF CONGENITAL CATARACT.

By GEORGE LAWSON, Esq., Assistant-Surgeon to the Royal London Ophthalmic and the Middlesex Hospitals.

[Concluded from page 83.]

As a rule, no urgent symptoms follow the first stage of the operation of linear extraction. Frequently, some little irritation exists for a few days; but oftentimes the eye continues so quiet, that one can hardly imagine that any operation has been performed. Still, on the other hand, grave symptoms occasionally arise, and require to be actively dealt with; for an eye with a congenital cataract is usually below the standard of strength, and succumbs quickly to sharp inflammatory action.

Supposing the operation to have been well conducted, and the case apparently a good one, the great cause of untoward symptoms arising, is pressure of the swollen lens itself, or of some of its particles on the posterior surface of the iris. Large pieces of lens matter may float freely in the anterior chamber—may even apparently almost fill it—and fragments may lie on the anterior surface of the iris, without producing any unpleasant symptoms, but the pressure of a portion on the posterior surface may act as such an irritant, as to kindle an amount of inflammatory action sufficient to destroy the eye.

To avoid, as far as possible, the chance of such a contingency, the pupil should be kept widely dilated with atropine, so that the particles of lens matter as they swell and detach themselves from within the capsule, may float through the widely dilated pupil into the anterior chamber. Sometimes, although the capsule has been freely broken on its anterior surface, yet the matter within has not been sufficiently comminuted, so that the lens, swollen by the action of the aqueous on its substance, and unable to discharge itself by fragments into the anterior chamber, presses by its entire surface on the posterior or uveal surface of the iris, and so becomes the source of great irritation. The reverse of this may, however, take place. The lenticular matter may have been freely broken up, but the aperture in the lens capsule may not have been made sufficiently large to allow of the ready escape of the particles after they have become swollen from the action of the aqueous on them, and so the enlarged lens presses on the back of the iris.

The symptoms which would be present would be those of great irritation; severe neuralgia over the

brow, around the orbit and in the eye itself, with a considerable amount of photophobia; the eye more red than normal, and the ciliary zone manifest; the aqueous muddy, and the pupil at first sluggish, then quite inactive and incapable of being dilated with atropine. Such symptoms as these call for immediate treatment. If they commence a few hours after the operation, or on the following day, it will be well to apply one or two leeches to the temple, and repeat one night and morning for two or three times. This local abstraction of blood often affords a most speedy relief, and at once arrests all excessive action. Act freely on the bowels with some moderate purgative, and keep the eye cool with a piece of linen moistened with cold water applied over it, and let the room in which the patient resides be darkened.

If no abatement follows the treatment, and the symptoms of irritation continue, the cause is very probably the swollen lens pressing on the iris, and it is advisable to get rid of this source of irritation by removing it, or as much of it as possible, and at once to perform the second part of the operation of linear extraction.

The second stage of linear extraction consists in removing the broken-down lens through a small linear opening in the cornea. Before it is attempted, if all has gone well, and nothing has happened since the first operation to necessitate its immediate performance, sufficient time should be allowed to elapse to allow all the transparent portion of the lens to become opaque and somewhat macerated by the aqueous. From three to six days will be about the time required for the desired changes to take place, but much depends on the condition of the cataract at the time of the operation, and upon the extent to which the capsule has been torn and the lenticular matter broken up. This stage of the operation requires great caution.

1. As to the part at which the broad needle should be introduced, and the mode in which the opening should be made in the cornea.

2. In allowing the lens, which is now diffuent, to run off on a curette, taking care not to bruise or in any way to injure the iris, or the posterior layer of the lens capsule.

The patient lying on his back with the face to the light, the eye is to be kept open with a spring speculum, and steadied by being held by the operator with a pair of forceps. The broad needle is used in his right hand for the right eye, and in his left hand for the left eye, to make the linear opening in the cornea. The outer portion of the cornea is the most convenient, and the part usually selected in each eye for this operation.

1. With reference to the opening to be made in the cornea. The pupil being widely dilated with atropine, the needle should be made to perforate the cornea at the point just external to where the pupillary margin of the iris is seen, and instead of penetrating it directly from before backwards it should be made, as Mr. Bowman has suggested, to pass obliquely inwards through the laminae of the cornea, and then by a slight cutting motion in its withdrawal, to enlarge the opening to its necessary length. The aperture thus made will be valve shaped, the external opening in the cornea being nearer to the circumferential margin than the internal, the object being, that the curette in and after its introduction, shall not press at all upon the iris, but in making the many movements which are required, shall rest solely on the inner lip of the valve-shaped orifice in the cornea. Frequently before withdrawing the broad needle it may be well to dip it towards the lens, and break up more completely any large fragments which may remain. Another advantage in thus making the opening well within the margin of the cornea is, that

prolapse of the iris does not occur, whereas when the linear incision is made close to the corneal margin, a protrusion of the iris is very apt to follow the aqueous with the soft lens as it runs off on the curette. A sufficient opening having been made, the curette is next to be introduced, and this should be done with a gentle lateral motion. The eye being still held by the surgeon with a pair of forceps, in the most convenient position, the curette is moved gently from side to side, pressing slightly on the mouth of the wound to permit the aqueous with the softened lens to flow down its groove. When the largest portion of the lenticular matter has escaped, here and there small opaque pieces will occasionally be seen which have not flowed away in the stream; these may be followed with the curette, and on the point of it being dipped as it were beneath them, they will also escape along its groove.

When the pupillary space is clear, it is advisable not to be too eager to catch every little opaque patch of soft matter, as oftentimes some little fragments will lie in front of the iris, difficult to get at, and more harm may be done by seeking for them than their presence can produce. All the movements of the curette should be conducted with the utmost caution, as it is highly essential that the posterior capsule should not be broken, for should such an accident occur, the vitreous will immediately come forward, as the hyaloid must be ruptured at the same time. One of the great troubles occasioned by the flowing forward of the vitreous is, that mixing with the opaque portions of the lens, which have evaded the curette, it becomes often next to impossible to remove them, as coated with the tenacious vitreous, they elude the point of the curette, and instead of falling into its groove and escaping by it, they are pushed about the anterior chamber in front of it.

The lens having been removed, or as much of it as will readily flow away, the patient is to be sent to bed in a darkened room, and the pupil is to be kept under the influence of atropine. This is generally necessary, as it is very common to leave behind some soft matter, which not having been acted on by the aqueous, remained transparent at the time of the operation, and so escaped the notice of the operator. If towards evening there is pain, one or two leeches should be applied to the temple, which may be repeated if it continues. The frequent small abstraction of blood has a most beneficial effect in arresting any untoward symptoms which may present themselves at this early period after the operation. The pain in the eye increasing, will call for warm and soothing applications, and of these the belladonna fomentation will afford the most comfort. If the eye should become hard, its tension increased, a simple puncture of the cornea with a fine needle, and allowing the aqueous to escape will give great ease. This operation is very simple, and may be repeated several times if necessary.

Iritis is the affection most to be dreaded after this operation. Its presence is suspected by a continuance of pain in and around the eye, but an examination of the eye itself will at once confirm or refute the suspicion. The serous aqueous, the muddy iris, and the ciliary zone of vessels around the cornea, give evidence of internal inflammation. With this form of iritis, there is always intolerance of light and considerable lachrymation. There is an acute and a chronic form of iritis which occasionally follows the operation of linear extraction. The acute may run its course in a few days and destroy the eye, or it may gradually subside to a certain point, and then become chronic. The chronic form commences from one to three weeks after the operation, and is the cause of great trouble to both the surgeon and patient. It is

always accompanied with photophobia and lachrymation, and the edges of the lids often become puffy, thickened, and excoriated. The aqueous continues serous, and the striation of the iris indistinct. The pupil is but slightly and irregularly acted on by atropine, and there is a slow dull pain in the eye. This chronic condition will last frequently many weeks. It yields but slowly to treatment. Counterirritants behind the ear repeated from time to time sometimes do good; but as a rule, all applications to the eye should be soothing, and the treatment tonic. Belladonna in one form or another should be applied to the eye to relieve pain and keep the pupil dilated, and occasionally a moderate mercurial inunction may be necessary.

Extraction of the Lens by Suction. This mode of treating congenital cataract has been lately reintroduced into practice, and the success which has attended it, makes it probable that it will be largely adopted. In the last number of the *Moorfields Ophthalmic Hospital Reports*, Mr. Pridgin Teale of Leeds has given an account of several cases which he has operated on successfully with a suction curette designed by himself. In his instrument, the suction power is applied by the mouth through the medium of a flexible tube attached to a tubular curette fixed in a handle. The hand which holds the curette is able to act independently of the suction, and is quite free and unfettered in its movements.

Mr. Bowman has tried this mode of treatment in many cases with very favourable results, and has used an ingenious syringe made at his suggestion by Messrs. Weiss. The suction power is obtained through a delicate metal syringe placed at one extremity of a glass tube, which is furnished at the other end with a tubular curette. The syringe is so contrived that its piston can be worked by the hand which both holds the instrument and guides its movements within the eye, leaving the other hand free to steady the eye with forceps.

Mr. Bader of Guy's Hospital has also had a suction tube made by Khroné of Whitechapel. The suction power is a small hollow India-rubber ball, placed at the extremity of a tube which terminates in a glass tubular curette. Pressure is made on the ball with the hand, to expel the air from the tube, and its readmission is regulated by a well contrived stop apparatus placed close to the curette. After the air from the ball has been expelled and its readmission prevented by closing the stop, the curette is introduced into the eye, and the amount of suction is regulated by a little trigger connected with the stop apparatus within.

The extraction of the lens by suction may be performed in one operation, but my own feeling is, that it is better at the first operation to thoroughly open the anterior capsule of the lens, and break up the lenticular matter, and allow it to be well acted on by the aqueous before using suction to extract it. Should the lens be very soft and the cataract complete, one operation will suffice. The pupil having been first fully dilated with atropine, a fine needle is introduced through the cornea and the capsule freely torn, and the lenticular matter broken up. A larger opening is then made in the cornea with a broad needle, immediately within or on a level with the pupillary margin of the dilated pupil, sufficient in size to allow of the easy entrance of the tubular curette of the instrument to be employed for suction. A delicate manipulation of the instrument is required to move it from point to point, so as to place the open mouth of the curette in the most favourable position for sucking in the lens matter. The suction power must be carefully regulated by the operator, who is able to arrest it instantly when required.

If, however, the cataract is not complete, but a considerable portion of the lens is transparent, then I believe it is advisable to divide the operation into two stages, and first to perform the preliminary part of the operation for linear extraction, tear up the anterior capsule of the lens, and comminute the lenticular matter within, so that it may be exposed to the action of the aqueous. Two, three, or four days having elapsed, the suction part of the operation may be performed, and the whole lens, now opaque and diffuent, will be readily drawn through the tubular curette of the instrument. The attempt to remove a lens which is not completely opaque, is met by two difficulties.

1. The transparent circumferential portion of the lens is always sticky and adheres to the inner surface of the capsule, and it is difficult, if not impossible, to remove the whole of it.

2. From a portion of the lens being transparent it is impossible to say when the whole of it has been removed, as the opaque portion only is visible to the operator. By first allowing the aqueous humour to act on the lens matter, the transparent portion becomes opaque, loses its tenacity, and is readily sucked up into the tube.

5, Harley Street, Cavendish Square.

Transactions of Branches.

SOUTH WESTERN BRANCH.

PRESIDENT'S ADDRESS.

By C. B. NANKIVELL, M.D., Torquay.

[Delivered July 20th, 1864.]

GENTLEMEN,—The position in which you have done me the honour to place me, forcibly impresses me with the truth of the ancient allegory—that “Pleasure and Pain are twin sisters.” The pleasure of receiving the members of the Branch Association here to-day, is strongly mingled with the fear that I shall utterly fail in my efforts to render their visit either useful or agreeable; and this would certainly have been the case, had not medical friends in this place come forward with the greatest readiness and cordiality to aid my endeavours. I am sure that in their names, as well as in my own, I may offer you a hearty welcome to Torquay.

It so happens that I was one of those who, in 1832, met at Worcester, for the purpose of forming a Provincial Medical and Surgical Association; and well do I remember the observation of a friend, with whom I had gone to that meeting, that it would be “interesting to watch the further progress of the profession and the future career of those then assembled.” Before three short years had passed, the career of this friend had ceased, and he had become the subject of one of the first biographical memoirs published in our *Transactions*. In him the twin sisters had indeed, *pari passu*, run a rapid course. Very few of the fifty who met on that occasion now remain.

But if it was interesting then to look forward to the probable future of our profession, how much more so, and how much more satisfactory, is it now to look back on what the profession has accomplished since that day. Time will only permit of my glancing at a few of the most important events in this period of our history.

It is satisfactory to see that the small body of associated medical men, who met at Worcester, has gone on augmenting by yearly additions to its numbers until it has amounted to thousands, and until it has spread its branches over the whole of Great

Britain, so as to earn and merit for our society the title of the British Medical Association; and, although more might perhaps have been done, and more certainly may be accomplished by the Association, no one can peruse the reports of its proceedings, not excepting its early *Transactions*, without advantage; and for myself, I may truly say that I never attend its meetings without gaining some information, and without being drawn by closer ties of friendship towards many of its members. It must be allowed, too, that the BRITISH MEDICAL JOURNAL has much improved in character under the direction of its present zealous and spirited editor; though, while acknowledging the value of the JOURNAL, and the talent with which it is conducted, one cannot but regret that it should absorb almost the whole of our funds, leaving so small an amount to be applied to other useful objects.

Still more gratifying is it to reflect on what has been achieved by the profession generally since the origin of our Association—just to recall, for one moment, a few of the great and striking conquests, since then, of our body militant, ever combating disease and pain.

At that time, Sir Charles Bell had not long promulgated his great discoveries, and scarcely anything was known of the minute structure and functions of the several parts of the nervous system; the observations of Laennec had only just been brought before the British medical public; Hope had not published his work on *Diseases of the Heart*; Bright's researches were little known, and not at all appreciated, though preceded by the observations of Blackall, of whom our Branch of the Association may be so justly proud. The microscope had scarcely been applied to physiological, and still less to pathological investigations; and animal chemistry had done little or nothing for either of these departments of medical knowledge. Uterine pathology, the distinction and pathology of fevers, and the pathology of various other blood-diseases, was vague and uncertain.

How vast has been the flood of light thrown on these several departments of medicine since then! But to one engaged in the daily practical work of medical treatment, scarcely anything appears of more daily practical value than the great advantage afforded in the present day, as compared with the past, by the employment of physical signs in the discovery and diagnosis of disease. It is hardly necessary for me to say how much we are indebted in this way to the microscope, to animal chemistry, the stethoscope, mensuration, percussion, palpation, the use of various specula, the uterine sound, the ophthalmoscope, and the laryngoscope; and latterly, the thermometer placed in the axilla has been usefully employed on the same principle. The origin, too, of our Association was at the time of the terrible epidemic which almost inaugurated the study of preventive medicine in this country, and rendered the great body of medical men the leaders of sanitary reforms.

Surgery has likewise undergone great changes and improvements since 1832; and long since then has rejoiced in the birth of what has been called the handmaid of operative surgery, the use of anæsthetics, so invaluable in the facility it affords in performing some of the great operations of the present day.

Not less remarkable have been the changes in the treatment of disease; and in nothing is this more exemplified than in the use of the lancet. We all know how seldom this instrument now pierces the veins of our patients; but in the fourth volume of our *Transactions* you will find, amongst others, a case described by Dr. Barlow, the leading physician of Bath at that day, to be one of ovarian disease, in which the patient was bled forty-five times to the extent of 384 ounces,