

AMAUROSIS URÆMICA.

In this class of cases there are no intra-ocular changes except in some rare instances. There is œdema of the retina, which passes away in a few days, or more rarely it is so marked as to cause a separation of the retina by serous infiltration, as in the case reported by Heyl, where retinal separation in the right eye and uræmic amaurosis in the left occurred simultaneously. As to the cause of the blindness in uræmic amaurosis, Traube's theory seems at present to hold good. He considers the cerebral symptoms of uræmia to be due to acute anæmia of the brain, caused by œdema of the brain-tissue, due to the circulation of urea in the blood. The blindness in these cases is sudden and complete, and it usually is associated with a group of uræmic symptoms,—convulsions, etc. The treatment of this, as of the other ocular symptoms occurring in renal diseases, needs no special local measures; the treatment of the general disease is the best that can be done for the eyes. As regards the prognosis of retinitis albuminurica not associated with pregnancy, the duration of life does not, as a rule, exceed eighteen months. Thus it behooves us all, gentlemen, when we do not adhere to the code of health of the "school of Salernum," which says,—

"At least six times in every fleeting day
Some tribute to the renal function pay,"—

to consult some fellow-practitioner.

TREATMENT OF ACUTE PURULENT CONJUNCTIVITIS AND OPHTHALMIA NEONATORUM.

CLINICAL LECTURE DELIVERED AT THE NEW YORK POLYCLINIC.

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GENTLEMEN,—The other day we considered the treatment of the severer forms of purulent ophthalmia. Continuing this subject, I may say that considerable importance is to be attached to the proper cleansing of the eye, and whether an antiseptic solution is to be employed or not is for you to decide, and will depend upon the extent to which your mind or your imagination is carried away with the present views concerning the advantages of antiseptics. Personally, I think cleansing the eye with lukewarm water is as good as anything. It should be done by a competent nurse, the pus being wiped away with absorbent cotton every thirty minutes or oftener. The cotton should be destroyed after each washing. The cleansing of the eye by the use of syringes should be severely condemned, for it is obvious that the attendant is subjected to the danger of contamination with the secretions from the patient, and also because it is very difficult to control the force of a stream from a syringe, and if the cornea be weakened, as it often is, by the disease, you favor the rupture of the eyeball. A great variety of antiseptics are recommended; some use carbolic acid, others bichloride, and still others boracic acid.

Let us speak of the treatment of what may be termed the complications which arise in the course of severe purulent ophthalmia; and, first of all, let me urge you to examine such eyes with great care, for it is not always an easy matter to tell when the cornea is implicated. In a very severe case of gonorrhœal ophthalmia which I had under treatment, I told one of my colleagues I thought there was a perforating ulcer in the upper corneal margin, but he could not see it until I suggested that he raise the chemotic conjunctiva which

covered it. It is in this locality that you so often find these ulcers, and if seen when the ulcer is well formed it has a perfectly transparent base, making it difficult to determine that the ulcer is really present. If ulceration be not present, you may find infiltration,—*i.e.*, the cornea is rendered opaque by either serous or purulent infiltration. In the severer cases there is infiltration of the cornea nearer to its centre, or even the whole corneal membrane may be invaded. When the whole cornea is infiltrated with pus, sloughing is of course inevitable. Now, if the process of ulceration lead to perforation of the cornea, what is to be expected if this occur at the corneal margin? The eye is by no means lost. The perforation may be such that the iris is prolapsed, and if this occurs, one rule should always be followed here which is not applicable in other cases,—*i.e.*, to avoid abscission. If you excise the iris, you favor the invasion of the purulent material into the interior of the eye. If ulceration is imminent, it may be sometimes averted by the use of eserine. Instil a solution of eserine, one-half per cent. or weaker,—for a stronger solution has a tendency to provoke iritis. It probably acts by relieving the intra-ocular tension, and the danger, of course, is that the normal intra-ocular tension may cause rupture. Many advise the performance of paracentesis when the ulcer is very deep, but this I never do, for I think it is better to employ the eserine; and if rupture occurs in spite of this, I think I have done all that is advisable.

The purulent process may extend to the interior of the eye, and this is almost necessarily fatal to the integrity of the eye; for if there be considerable sloughing of the cornea, and the purulent process reaches the interior of the eye, in all probability there will be a panophthalmitis,—an extension of the purulent trouble to the interior of the eye,—and this is to be deplored on account of the certain loss of sight, and also because the pain is thereby greatly increased.

Another and not infrequent complication is iritis. In all of these corneal diseases, and in iritis also, it is well to employ atropine for the alleviation of pain, and, above all, in iritis, to prevent the adhesions between the iris and the lens. In two or three of my cases where iritis has complicated these purulent cases, there has been an extensive exudation into the interior of the eye,—into the anterior chamber and into the pupil. I am not sure that this is a special feature of this complication, but it would seem probable. The exudation was what is known as "spongy exudation." This was first described minutely by Dr. Gunning, of Amsterdam, and afterwards by Dr. Gruening, of this city. The latter gentleman showed that the gelatinous exu-

dation was but one of the stages of a spongy exudation. This exudation forms very rapidly and completely fills the pupil, and often also the anterior chamber. It resembles very closely the structure of a sponge, and hence the name of spongy exudation, which I believe was first given to it by Dr. Knapp. It consists of fine filaments which cross one another in all directions. When examined by oblique light, it resembles very closely the microscopical appearance of a bone-corpuscle. Within twenty-four or forty-eight hours it will change to a whitish homogeneous mass, which looks like a cataractous lens dislocated into the anterior chamber, and then absorption begins at the periphery and continues until it is entirely absorbed. You may achieve considerable reputation by your prognosis in such a case, for it alarms the patient, and yet you can certainly predict that within a few hours it will have all disappeared.

Extending our remarks to ophthalmia neonatorum, we find that the manner of invasion of the cornea is not essentially different from that already described. The examination of the patient is somewhat troublesome, yet you must remember that it is your duty to examine the condition of the cornea in all these cases at least once in every twenty-four hours. In young children, corneal complications, especially infiltrations, are not so much to be dreaded as they are in the severe forms of purulent ophthalmia of adults due to infection.

If we turn now to a consideration of the conditions remaining after recovery from a purulent process in the conjunctiva, we find that a good many eyes may be saved from absolute blindness, both in adults and in the new-born. There may be an opacity of the cornea as a result of the purulent process,—*i.e.*, a change in the entire corneal structure, constituting what we call leucoma. This leucoma may be simple or adherent,—that is, the iris may be adherent to some part of the scar in the cornea. It results from the substitution for the corneal tissue of some newly-formed connective tissue, which remains perfectly opaque. If a portion of the cornea remains clear, you often secure fair sight for these patients by an iridectomy. In a great many cases of this kind, and especially after ophthalmia neonatorum, iridectomy is rendered very difficult, because the iris is adherent to the scar and is put on the stretch, and the anterior chamber is shallow; nevertheless, in very many cases you can make the distinction between a simple perception of light, or slight useful vision, and absolute blindness by carefully searching out some portion of the cornea which is clear and performing an iridectomy in this locality. The operation often cannot be done with the ordinary iridectomy knife, in which case

Graefe's knife will have to be employed. Often the iris cannot be grasped by the common iridectomy forceps, and then you must use the iris forceps of Matthieu, and if these fail you may use Tyrrell's hook. Besides these cases, there are some with staphyloma. I recently showed you a case where there was a total staphyloma. Here there can be no recovery of vision; but if only a part of the cornea be invaded by staphyloma, you may quite often restore vision to the eye. Thus, in the case of a boy recovering from gonorrhoeal ophthalmia, where the whole upper third of the cornea was the seat of a dense leucoma, which afterwards became staphylomatous, and where the iris was transparent in the direction of the scar, I restored very good sight to the patient. The first thing I did was to perform K uchler's operation for staphyloma, which consists in dividing the staphyloma throughout its entire length in the vertical meridian. The lens may lie under the staphyloma, and if so you evacuate the lens; if not, you cut from each lip of the horizontal wound you have made a narrow strip of the leucomatous tissue. The eye is now to be kept persistently bandaged for several weeks, when it will be found that there is a flat leucoma instead of a protrusion. After this, you can perform an iridectomy, as I did in the case just alluded to, with the result of securing him very useful vision. As the outcome of long experience, I would say, never make a perfectly hopeless prognosis in ophthalmia neonatorum, except where there has been almost complete sloughing of the cornea.

Laryngology and Rhinology.

NASAL CATARRH.

CLINICAL LECTURE DELIVERED AT THE BELLEVUE HOSPITAL MEDICAL COLLEGE.

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NASAL OBSTRUCTION.

GENTLEMEN,—This young lady came to me complaining of marked obstruction in the right side of the nose. With the Jarvis "nippers" I removed sufficient cartilage to relieve the obstruction partially, but, for some unaccountable reason, the tissue on the right side, instead of being cartilaginous down to the nares, seemed to be bony, and I found it necessary to use the Bosworth saw. The operation was done only a few days ago, so that some of the obstruction still present is due to the granulation-tissue; but more tissue will probably have to be removed.

IMPERFECT SPEECH-DEVELOPMENT.

This young man came to me the other day and said that a horse had kicked him in the temple seven years ago, and that following this there was trouble with both ears, but no loss of consciousness, and no paralysis of the limbs. Examination shows nothing wrong in the throat or nose. He has a marked impediment in his speech, which is probably due to a central lesion in the frontal convolution on the right side, and which is not within the reach of medicinal or operative treatment. It is not an instance of aphasia, for he knows what he wants to say, but his speech is imperfect. I shall refer him to an elocutionist, in the hope that by education his speech may be somewhat improved. I do not recall ever having seen such a case before.