

leprosy affections of the skin has been purposely omitted. This was dealt with in a paper published in the *British Medical Journal* for Feb. 5th, 1887, p. 276.

Like Dr. Wynne and other writers, I have often found leprosy bacilli in cells as well as free.¹ I have always failed to find them in anæsthetic patches and ulcers, in necrosed bone, or in the blood. In only two instances were they found in the kidney. During the last six years I have made ninety-three necropsies on lepers at the Trinidad Asylum, and 788 examinations of viscera and other tissues for leprosy bacilli, so that experience is still accumulating, and I hope to tabulate it further before long.

One point comes out very clearly from the tables published so far—that the bacilli are far more widely distributed in the tuberculated and mixed forms than in the anæsthetic; indeed, in the latter it is very rare to find them anywhere but in the median nerves.

I am, Sirs, yours faithfully,

Trinidad, Jan. 26th, 1890.

BEAVEN RAKE.

TREATMENT OF VITREOUS OPACITIES.

To the Editors of THE LANCET.

SIRS,—In your last issue is a paper by Mr. Vernon Ford on a new form of treatment for vitreous opacities. While admitting the difficulties in the way of curing such cases, many points occur to one in considering the somewhat heroic treatment proposed and practised by Mr. Ford. In the first place, I understand he proposes to evacuate the whole vitreous, a small quantity at a time, by successive punctures with a trocar. This alone must be a very difficult proceeding, for unless the vitreous were very fluid, it would be difficult to get it to flow along a fine trocar, and then the tendency would be for the opacities, which are often large and membranous, to remain behind. Secondly, vitreous is never re-formed, but its place may be taken by freshly effused serum, which may at first be transparent, and so vision may be slightly improved for a short time. In the case quoted useful vision was not obtained, although there was some improvement. Then it would be essential to know the condition of the eye at the end of twelve or eighteen months, and I should venture to predict that at the end of that time Mr. Ford will have a case of a shrinking eye without any vision at all. I have lately been treating cases of vitreous opacities with subcutaneous injections of pilocarpine. In two cases great improvement took place, while in others the result has seemed *nil*.

I am, Sirs, yours faithfully,

GUSTAVUS HARTRIDGE, F.R.C.S.,

Surgeon to the Royal Westminster Ophthalmic Hospital &c.
Green-street, Park-lane, W., March 5th, 1890.

AFFECTIONS OF THE MIDDLE EAR DUE TO INFLUENZA.

To the Editors of THE LANCET.

SIRS,—Several cases of otitis media due to influenza have lately come under my notice. They are of such an unusual and typical nature that it may be of some interest to record them. I should like to divide the cases into two classes—i.e., those cases which come on at the same time as the influenza and those which come on a week or ten days later. The symptoms are the same in most respects, except that in those cases which come on at the same time as the influenza the pain is perhaps more severe, more intermittent, the general prostration greater, and the duration of deafness shorter than in those cases which come on after the influenza. The symptoms of ordinary otitis media and those of otitis media due to influenza are in many respects quite different. In the latter the pain comes on more suddenly, and is more of a neuralgic nature. The pain is distinctly intermittent, and worse at night, when the attacks are more frequent and last longer than at daytime. The pain does not at all correspond to the objective symptoms. In fact, there is that marked incongruity between the objective and the subjective symptoms which is so very characteristic of all cases of influenza and of their complications. There is little or no relief after the artificial or natural perforation of the drum-head, which is invariably the case in cases of ordinary otitis media. The deafness comes on gradually for a few days, is then usually

well marked, and lasts in most cases at least two or three weeks, sometimes much longer. There is great nervous prostration, which lasts for some weeks, the patient is very nervous and excited, and cannot sleep. The drum-head is intensely red, swollen, and in some cases there is distinct extravasation of blood. There is never much serous or purulent discharge, sometimes very little indeed. The mucous membrane of the middle ear is very much swollen, and, in many cases, granulations or polyp form. This accounts for the fact that Politzer's method does not relieve the deafness, and also that the deafness often lasts for a long time after the other symptoms have apparently all disappeared. There is never that peculiar oedematous swelling of the mastoid process which is so frequently seen in the ordinary otitis media. The mastoid process is in some cases intensely painful on pressure. In two cases the external meatus was swollen, but not painful.

As regards treatment, I should, as far as my small experience goes, recommend the daily application of two leeches, one in front of the tragus and one on the mastoid process; hot antiseptic fomentations; no poultices. Cocaine ear drops (10 per cent.) seem to give more relief than glycerine of carbolic acid, which is so very useful in ordinary cases of otitis media. If the pain and deafness last longer than a few days, I should recommend a very large incision to be made in the drum-head. This not only relieves the local hyperæmia, giving free exit to any exudation, but also permits of the local application of astringents to the mucous membrane of the middle ear. On this latter point I should like to lay particular stress. Nitrate of silver drops (10 per cent.) seem to act better than chromic acid, spirit of wine, alum, zinc, &c. In two cases I used insufflations of iodoform and cocaine, and with good results. Antipyrine or small doses of morphia help to relieve the pain. In some cases large doses of sulphate of quinine gave much relief. Politzer's method ought never to be used till the pain has ceased, and then it does not seem to be of much use. The peculiarities of these cases seem to be: (1) The marked incongruity between the subjective and objective symptoms; (2) the sudden, often very acute, and invariably intermittent pain; (3) the peculiar redness and well-marked swelling of the drum-head, and also of the mucous membrane of the middle ear; (4) the fact that the artificial or natural perforation of the drum-head fails to relieve the pain or deafness; (5) the small amount of secretion; and (6) the fact that the deafness gradually increases for two or three days, and then persists often for several weeks, long after all other marked symptoms have disappeared.—I am, Sirs, yours obediently,

ADOLF BRONNER, M.D.,

March, 1890

Surgeon, Bradford Eye and Ear Hospital.

CHEYNE-STOKES RESPIRATION.

To the Editors of THE LANCET.

SIRS,—Dr. Stephen Mackenzie asked last week, at the Clinical Society's meeting, *à propos* of Dr. Samuel West's case of Cheyne-Stokes respiration, whether any observer had known a case in which this phenomenon was developed to recover.

I saw recently, in consultation with Mr. W. H. Rean of Brighton, a lady, slight, delicate, and asthmatic, aged sixty-six years, who was suffering from influenza and broncho-pneumonia at the base of the left lung. The patient was thought to be dying. Delirium had been succeeded by drowsiness, alternating with periods of some mental activity. The right side of the heart was evidently much loaded, and the heart's action exceedingly irregular and jerky, but without bruit, temperature hypo-normal. The hands were chilly and perspiring, the lips purplish red, the power of swallowing was almost lost, cough was feeble, and expectoration, lately abundant, had ceased; the general aspect betokened approaching dissolution. The respiration, which was attended with a rattling noise from mucus in the throat, and which had been irregular and laboured, assumed and retained during one night the Cheyne-Stokes type. The acts were shallow, brief, about 40 to the minute, and of diminishing force, until a pause came lasting several seconds (perhaps ten); after this the breathing recommenced slowly. During the pause the pulse was unaltered, its rhythm being throughout very irregular, and the rate about 120 to the minute. The pauses varied in frequency, sometimes only six respirations came between them, sometimes much more. There was no apparent alteration of

¹ Path. Soc. Trans., vol. xxxviii., p. 439.