geons of ability fail in attempting to remove a loose cartilage according to this method. He therefore prefers direct incision with antiseptic precautions. The cartilage is to be fixed by the aid, cut down on, and held by a hook between the lips of the incision. After freeing the surrounding tissues the pedicle is cut (if it is present), and compression is made to prevent the entrance of air into the articulation. In Richet's experience antiseptic precautions had not always conferred the immunity from secondary inflammation he had expected.

Gaujot¹ believes that surgeons have generally discarded the subcutaneous method in favor of the open incision, partly on account of the uncertainty of the former, and partly because statistics appear to show that the mortality at present from the subcutaneous incision is greater than from the direct incision (13 per cent. and 7.05 respectively). Gaujot has collected fifty-four cases where the results were as follows: twenty-nine dressed with the Lister dressing, twenty-seven recovered, two died; three, the simple Guérin cotton dressing, all recovered; three, cotton dressing with antiseptic precautions, two recovered, one died; seventeen with dressing to exclude air, but not a strict Lister dressing, one died, the others recovered. (In these latter cases great care was taken in the operation to prevent infection.) According to the writer, if the foreign body is a result from a proliferation of the synovial membrane, and not a portion of the cartilage separated by an injury, a relapse may be expected.

TRANSPLANTATION OF TENDON.

Nicoladoni,² in a case of pes calcaneus with paralysis of the calf muscles, "grafted" the peroneal tendons on to the stump of the tendo-Achillis, which had been divided. Healing by first intention followed, and the patient was found to have gained in walking and in plantar flexion.

Beger³ describes a method of fixing the head in cervical caries. An ordinary plaster jacket is placed around the trunk; in this two strips of bent iron are incorporated, extending from the trunk to the head; this latter is fixed to the iron by plaster bandages, which should extend far enough down on to the head to hold it firmly. The writer claims that the head can be secured in this way so firmly that when strips of adhesive plaster applied to the head for suspension are cut the extension is still maintained.

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¹ Revue de Chirurgie, 1881, No. 5.

² Centralblatt f. Chirurgie, page 701, November 5, 1881.

³ Berlin. klin. Wochenschrift, 1881, No. 33.

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Hospital Practice and Clinical Memoranda.

TWO CASES OF CONGENITAL IRIDEREMIA, WITH LAMELLAR CATARACT IN ONE AND DISLOCATED CATARACTOUS LENSES IN THE OTHER.

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CASE I. N. J. M., aged twelve, says that he knows of no defect in the eyes of any other member of his family in this or preceding generations, except that his mother is "short-sighted." He is of medium size and, except his eyes, well developed.

His vision is $\frac{3}{60}$, and is not improved by glasses or the stenopaic hole. There is no photophobia, and he sees better in a bright light than in a subdued one. The corneæ are clear, but perhaps very slightly below the normal size, though a constant and decided nystagmus makes it impossible to measure them accurately. The eyes are free from irritation, and their tension is normal. There is not a vestige of iris in either eye

There is well-marked lamellar cataract in both eyes. In each lens there are two opaque layers with clear lens matter intervening between them, beautifully seen by oblique illumination. Only occasional and partial glimpses of the fundus can be obtained, but the choroid seems normal. There is not sufficient vision for any satisfactory test of the accommodation.

CASE II. I. B., a well-grown boy of thirteen years, has rather prominent eyes, with full-sized corneæ, and normal tension, but the iris is entirely absent in both. In the right eye the cornea is quite clear, and, though there are floating opacities in the vitreous, the details of the fundus can be seen fairly well. The lens, which is of normal size, is opaque and white, and is dislocated upwards, so that only about its lower half is seen beneath the corneo-sclerotic junction. The ophthalmoscope shows a hypermetropia of $\frac{1}{2}$, which, assuming $+\frac{1}{2}$, to represent the loss of refractive power induced by aphakia in the emmetropic eye, indicates a structure of the ball corresponding to a myopia of $-\frac{1}{2}$. The choroid and retina appear normal in structure, but the optic disk is atrophied and greatly distorted, the vertical diameter being twice that of the horizontal, and the retinal vessels crowded to its inner edge; vision is only quantitative. There is no nystagmus.

In the left eye there is a diffused haziness of the cornea, which, together with a greater opacity of the vitreous than in the other eye, makes the details of the fundus invisible. The lens, which presents the same form of cataract as that in the right eye, is still further out of position, and only a narrow edge of its periphery extends below the margin of the sclerotic. The lenses seem to be held in their unnatural position by some attachment of their upper margins, while the lower are free, and they swing backwards and forwards, as if on hinges, with the movements of the balls. In the left eye the lens has caused an absorption of the tissues, against which it rests until the choroid has disappeared from above it, and the sclerotic is very much thinned and slightly staphylomatous. When the cone of light, concentrated by a convex glass, is thrown upon it from below, the outlines of the lens become distinctly visible through the sclerotic.

Though irideremia (iris and eremia, absence), or aniridia, is an extremely interesting anatomical curiosity, it can scarcely be said, in the present state of our knowledge, to teach any useful lesson in embryology or pathology. Numerous hypotheses have been suggested to account for its occurrence, but most of them are more fanciful than philosophical, and perhaps none of them are more rational than that maintained long ago by Von Ammon, who, in view of the late appearance of the iris, after the choroid is fully formed, considered its absence as simply the result of an arrest of development of the uveal tract. It is a curious fact that this anomaly is almost invariably symmetrical. According to Manz,¹ but one case has been reported in which it occurred in one eye only. Another point of interest in the history of this defect is its decided tendency to hereditary transmission. A number of cases of inheritance have been reported; one (quoted from Von Ammon by Lawrence) in which one member of the first generation was affected, three of the second, and five of the third.

The fact that cataract is very generally associated with irideremia has given some support to a suggestion that the iris is concerned in the nourishment of

the lens, and to an ingenious theory of the causation of irideremia, which supposes that the iris has been crowded out as it were, by the lens remaining too long and too closely in contact with the cornea during embryonic life. This coincidence of cataract with irideremia is, however, not constant, as cases are recorded in which the lens was transparent. One is reported by Dr. Reuling,² in which vision was sufficiently acute to enable the observer to determine that the power of accommodation was unimpaired.

The normal intraocular tension found in cases of irideremia has been adduced to prove that the aqueous humor is not secreted by the iris, but chiefly, if not entirely, by the ciliary processes. In the rabbit the ciliary processes are connected with the iris, and when both are removed the eye becomes very soft and the aqueous humor is never regenerated.³ This, so far as it goes, gives support to the advocates of sclerotomy instead of iredelectomy in glaucoma.

Partial congenital luxations of the lens are usually upwards, as in Case II., and frequently occur without defect of the iris. In the left eye of this patient the lens is so far out of place that it would be entirely concealed if the iris were present, and this case might then be readily mistaken for one of the very rare anomalies of congenital aphakia.

After the reading of the preceding paper, Dr. W. F. NORRIS said:—

"Through the kindness of Dr. Harlan, I have had an opportunity of making an examination of the eyes of the patients whose cases have been described. On first inspection of one of the cases I thought I could detect a slight peripheral remnant of the iris, but more careful examination, aided by the ophthalmoscope (oblique light), showed that every vestige of iris was wanting, that this appearance was due to the shadow cast by the limbus conjunctivæ corneæ on the periphery of the anterior chamber.

"It has occurred to me that at least some of the cases which have been reported in the older books as partial irideremia, might possibly be due to this similar appearance in the days when the above-mentioned methods of examination were unknown."

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SURGICAL CASES IN SERVICE OF DR. GEORGE W. GAY.

REPORTED BY R. A. KINGMAN.

I. PERINEAL SECTION.

THOMAS M., forty-four years old, was admitted with a stricture of the urethra and fistulæ in the perinæum. Had gonorrhœa twenty years ago, and for the last eight or nine years has noticed his stream of urine constantly diminishing in size. Two years ago he had two swellings appear just below the scrotum, which finally burst and formed permanent openings, through which urine has escaped ever since.

September 17th he was etherized, and the urethra thoroughly explored. It was found to be extremely irregular in shape, and to contain several very tough strictures, which would admit only a small bougie.

After enlarging the meatus by cutting, a Keyes's straight staff was introduced and carried down to the

² Am. Journ. Med. Sci., January, 1875.

³ Deutschman, Grafe Archiv, v., 26, No. 3.

¹ Handbuch, Augenheilkunde II., page 90.