the patient must be desired to move the eye in the four opposite directions, in order to display the cornea in different lights, and enable a full review of its surface to be taken. If no foreign particle can be found on the cornea, the lower lid being next depressed upon the cheek by the finger, and the globe upturned, the whole of the inferior portion of the conjunctiva may be carefully surveyed; and finally, by everting the upper lid, separating it by the finger from the globe, and directing the patient to look downwards, the upper half of the membrane is, with similar completeness, exposed to view. Of course, if any foreign body is detected its immediate removal is indicated.

Such is the ready way of setting any doubt as to the presence of a foreign particle at rest; but a general opinion on this question may be formed still more easily in many cases. As I have said, the vascularity of catarrhal ophthalmia is occasionally confined to the lining membrane of the lids; but a foreign body, unless fixed to the cornea, cannot produce such partial effect, for its presence equally irritates the conjunctiva of the lid and that of the globe. Hence, in any given case where the feeling of the presence of an extraneous body is vivid, but the vascularity is limited to the palpebral lining, and the cornea is free from extraneous particle, we know that the feeling is a deceptive one, and solely attributable to the disease under consideration. The diagnosis cannot be effected in this way if both portions of the conjunctiva, the ocular and the palpebral, are inflamed; because an extraneous substance and catarrhal disease may alike lead to this state. We must then resort to the more complete examination just described.

Generally speaking, there can be little difficulty in discriminating catarrhal from strumous or from purulent ophthalmia. Catarrhal, I have said, is destitute of any intolerance of light; of strumous ophthalmia intolerance of light is the most marked symptom. Catarrhal occurs at all ages; strumous, if not exclusively during childhood, certainly only during childhood and youth. Catarrhal may occur singly, while the person is in all other respects in perfect health; strumous invariably happens in debilitated subjects, generally is accompanied with other evidences of a strumous disposition, and often with facial or scalp eruptions, enlarged glands, abscesses, and so forth. Catarrhal ophthalmia is apt to involve the cornea in mischief only if neglected and long-continued, when it sets up that vascular condition already described at length; strumous displays a remarkable tendency to cause ulceration of the cornea.

Thus, then, gentlemen, so broad a line of distinction subsists between these two affections, that a moderate share of attention suffices for their discrimination. You will recollect that the catarrhal is the simpler, the milder, the more easily remediable disease; and that, if in any given case material intolerance of light exists, that case is not an example of pure catarrhal ophthalmia.

Again, with respect to the recognition of this malady from purulent ophthalmia, little real difficulty exists except in very rare instances; and yet I believe the two complaints have been often confounded, especially in military practice. The diagnosis here depends in considerable degree upon the severity of inflammation. Hence, as you have heard, chemosis is extremely rare in catarrhal cases; it is all but uniformly present in purulent, to a greater or less extent. Tumefaction of the palpebræ is seldom observed to any material degree in the former; in the latter it is of constant occurrence. The morbid secretion is in the former sufficient in quantity to accumulate in masses at the canthus, to clog the eye-lashes, and to produce agglutination of the lids; but in the purulent disease it is so abundant as to flow copiously from between the lids, to collect inside them when closed, and gush out, mingled with tears, when they are opened by the surgeon. Lastly, the nature of the secretion is different: in catarrhal ophthalmia it is opaque and thickened mucus, stringy and glutinous; in purulent (as is implied in the very name) the discharge consists of true pus.

It is needless to dilate further upon this subject. I have said enough to show how palpably the complaint now under consideration differs from others, and how readily ordinary care and knowledge will prevent mistake.

GRACEFUL RECOGNITION OF THE CLAIMS OF ASSISTANT-SURGEONS IN THE ROYAL NAVY.—Sheerness, Feb. 14th: The *Espiegle*, 12, Commander George Hancock.—An example has been set by Commander Hancock, which we hope to see followed by other commanders fitting out vessels of her class. Under the present Admiralty regulations for the accommodation of officers, no provision has been made for the assistant-surgeon appointed. Captain Hancock has given up one of his own cabins for the entire use of the assistant-surgeon, otherwise he must have been without a cabin for his personal comfort.—*Times*, Feb. 16th.

ON THE OPERATION FOR CLEFT PALATE.

By JOHN GAY, Esq., F.R.C.S.,

SURGEON TO THE ROYAL FREE HOSPITAL.

CHARLOTTE D—, aged twenty, a delicate-looking girl, was admitted into the Royal Free Hospital on December 9th of last year, having a congenital cleft of the hard and soft palates, and an imperfectly-united hare-lip, with a redundancy of substance in the lip itself. Mr. Gay removed the cicatrix and reunited the lip, with considerable advantage to the patient, and she was allowed to return home for a short period.

On January 11, she was re-admitted, in order to have the soft palate united, preparatory to the use of an obturator. The fissure of the hard palate was three quarters of an inch in breadth at its posterior part, diminishing somewhat anteriorly, where it tended to the left side, and terminated at a part corresponding to the interval between the left lateral incisor and canine teeth. The sides of the velum were healthy, and presented the usual muscular resistance on being drawn out. Deglutition was performed with greater ease than in some cases of cleft of the soft palate only, but her speech was almost unintelligible, and she was on that account exceedingly anxious to have the operation performed.

On January 21, Mr. Gay adopted the proceeding recommended by Mr. Fergusson, and which he has usually practised in similar cases—viz., section of the levatores palati and palato-pharyngei muscles, in order to relax the palate by depriving it of muscular action. This enabled the posterior valves of the velum to be approximated without difficulty; but the width of the cleft in the hard palate would occasion considerable tension of the flaps at their anterior part, when brought together, in consequence of the firm muscular and fibrous connexion of the velum with the posterior edge of the transverse plates of the ossa palati. To prevent such strain on the velum, Mr. Gay, in this case, as in the two others detailed, made a transverse incision immediately behind the hard palate; this had the desired effect, and the edges of the fissure having been previously pared, the parts were united by three sutures.

During the course of the operation, which was rather more tedious than usual, in consequence of the smallness of the patient's mouth, and the unusual depth of the soft palate, the parts bled rather freely; but the hæmorrhage was easily arrested by the use of iced water before the stitches were tied.

The inflammation following was of a healthy character; union by the first intention had taken place after four days, and two of the sutures were removed; the remaining one was removed on the fifth day, when union was complete throughout.

From the first she was allowed a necessary amount of nourishment; during the first two days, as there was some difficulty in swallowing, and she could only take a little arrowroot by the mouth, she was ordered a pint of strong beef-tea, with a glass of sherry, as an enema.

On the third day the bowels were freely relieved by a purgative draught. The palate was cleansed daily, and lightly sponged with a little myrrh lotion, which was accomplished without producing any pain.

The transverse incisions were scarcely visible by the time the sutures were removed, the divided parts having yielded to the increased breadth of the united velum.

As soon as the palate has regained its healthy tone, an obturator will be adapted to the cleft in the hard palate, thus completing the case.

MARY B—, aged twenty-one years, admitted under Mr. Gay's care, October 8, suffering from congenital cleft of both hard and soft palates, complicated with hare-lip and fissure of the alveolar arch, the division of the latter corresponding to the interval between the lateral incisor and canine teeth on the left side; there was also an irregular disposition of the front teeth, some of which projected in various directions; others were only partially developed, and bounded the sides of the cleft. The margins of the cleft were pared, and four sutures were introduced. The bleeding was inconsiderable, and had stopped before the stitches were tied. From the first, nutrient fluids were administered frequently and in small quantities. After five days, the parts having united, all but a very small piece in the middle, the stitches were removed, and the small aperture left closed subsequently by granulations.

MISS W—, of Manchester, aged sixteen. This young lady was afflicted with a cleft, extending, as in the other two cases, through the hard and soft palate; indeed, the hard palate was almost entirely wanting, being limited to a slight ridge

on either side. The distance between the edges of the imperfectly-developed horizontal plates of the palate bones was one inch and an eighth; the distance between the anterior molar teeth being one inch and four-tenths only. Owing to the absence of the lateral incisors, without any cleft of the alveolar arch itself, the alveolar processes of the superior maxillary bones took a straight instead of a curved course from behind, to their point of union anteriorly; from this condition of parts the fissure in the hard palate was angular, and diminished rather rapidly from behind forwards. The defect was one of great advantage to the young lady, and the question to be decided was, whether the soft flaps could be made to unite through the whole length, so that a gold obturator might supply the remaining deficiency. Mr. Fergusson saw this case, and doubted its practicability, owing to the extreme distance by which the soft flaps were separated. Mr. Gay determined, however, to make the trial, and adopted the method recommended by Mr. Fergusson, but in addition practised the transverse incisions before alluded to; by this means the flaps were released, and could be brought together mesially without tension. Four sutures were employed, and they were removed on the fourth day. This case was eminently successful, and an obturator was supplied, admirably adapted to the case, by Mr. Tibbs, the dentist of Finsbury-place, which has been worn since with the greatest comfort.

The three cases, detailed above by Mr. Lane, illustrate some important points in reference to the operation for cleft palate. The labours of Mr. Fergusson have rendered the treatment of these cases all but perfect, the remaining defect being limited to the frequent occurrence of a small aperture, which has to a certain degree compromised the value of the operation. I refer to the aperture which has very frequently remained between those portions of the edges of the flaps in immediate proximity to the tubercle of the hard palate, the edges of which will, on examination, be observed to be thinned off, and generally of a hard and fibrous character.

These apertures, after the healing of the remainder of the flaps, are of various sizes; in some cases they go on to closure, but their completely closing depends on two circumstances—first, the size of the aperture; and secondly, the general tension on the flaps; for, as was observed by Mr. Lane, at the Royal Free Hospital, these apertures heal or approximate towards closing, not so much by addition to the edges through the medium of fresh tissue, as by a stretching of the flaps generally towards the axis of the opening. In other words, the apertures are mainly closed at the expense of the flaps, and by an increase of their general tension; the result of which is, that when the call on that tension has been obeyed to the utmost, the power of further closing ceases.

It is desirable, then, to give increased freedom to the flaps, and especially at that part where their freedom is interfered with by their connexion with the bony palate.

When cases were presented to me in which the cleft extended itself throughout the bony as well as the soft palate, the question arose whether the latter could be united through its entire length; for on that being accomplished, a small obturator could easily be made to supply the deficiency in the hard palate, in case Mr. Avery's ingenious plan of closing it should not be feasible. The view ordinarily accepted—that in these cases there is no deficiency of soft parts; that where even the bony palate is limited to the merest ridge, still the soft palate is normally developed, although retained back by the deficient bony palate; moreover, that in children the soft palate has been known to become cleft after birth by a strain upon it in the act of crying, &c.,—led me to adopt the course that was successfully taken in these cases.

The results have shown, that as soon as the flaps are freed from connexion with the bone by *transverse incisions*, they unfold, and can be brought with the greatest ease into contact mesially.

It follows, then, that these transverse incisions, if made, but to a less extent, in the usual operation for a cleft of the *soft* palate only, will, by relieving the tension on the front part of the flaps, effectually prevent the defect alluded to—viz., the aperture which often remains an unworthy stigma on one of the most admirable and effective operations in surgery.

Moreover, these additional incisions will, to a certain degree, prevent that tension of the flaps which has been frequently observed to remain after their re-union by operation; and thus to render the palate better adapted for the performance of its functions, by making it more amenable to the muscular influences which act upon it.

Finsbury-place South, Feb. 1853.

CASE OF VITILIGOOIDEA.

WITH REMARKS.

By W. H. RANKING, M.D. (Cantab.), Norwich.

IN the summer of 1850, the following case presented itself to my notice, and a very brief inspection was sufficient to lead me to believe that I had encountered a disease, of which no distinct account had been given by writers on dermatology. I took notes of the case at the time, with reference to publication, but other occupations interfered with my intention, and the circumstance had all but escaped my recollection, when I met with the description of this disease, by Dr. Gull, under the term *vitiligoidea*, the identity of which with my own case could not fail to be recognised. The instances of this curious malady hitherto put on record do not amount to more than five. I have accordingly endeavoured to give a succinct account of what is known thereupon.

My patient, Mary B—, a married woman, aged twenty-nine, consulted me, in June, 1850, for obstinate and severe jaundice. Inquiry into her history elicited the facts that her health had been good until three years previously, when, after an attack of dyspepsia, jaundice supervened, and had continued till the time of her visit to me, uninfluenced by treatment, including several salivations. At this time she was universally and deeply jaundiced; but the appearance which immediately and more strongly attracted my attention was a peculiar deposit on the skin surrounding the eyes, and which, on further investigation, I found to be abundantly distributed over other portions of the body. She informed me that about twelve months ago spots of this peculiar deposit first appeared on the shoulders, and have since shown themselves on the face, arms, hands, and lumbar regions. In the face it has assumed a symmetrical disposition, extending along each eyelid, and down the side of the nostrils. On the shoulder the spots are circular, and very distinctly elevated. Along the inside of the elbows, and on the hands, the deposit follows the flexures of the joints, being flat and linear on the palmar aspect, and more tubercular and rounded on the dorsal. The colour of this deposit is of a whitish-yellow, resembling more nearly than anything else the atheromatous patches so commonly found in the aorta. On the face and palms of the hands it is but little elevated; and, as in atheroma, appears to be deposited immediately under the epithelium. On the shoulder and in the dorsal region the spots are circular and prominent, bearing no inconsiderable resemblance to split peas.

At the time of my seeing this case the peculiar affection was still on the increase, fresh spots showing themselves almost daily. They were tender to the touch, and were the seat of a burning sensation, which prevented the patient using her hands without acute suffering.

The history of the jaundice pointed to the conclusion that it depended upon permanent occlusion of the common duct. The woman died soon after my seeing her, under the care of another practitioner, and, as far as I could learn, from severe and rapid peritonitis.

The only references to this singular cutaneous disease which I have been able to meet with are contained in a paper published in "Guy's Hospital Reports;" for although Willan alludes to a rare disease under the term *vitiligo*, which has some points of resemblance, the full comparison of the two is unfavourable to the notion of their identity. The term used by Willan has, however, led Dr. Gull to give to the disease in question the name *vitiligoidea*. The cases narrated by him are four in number. The first is that of a married woman, aged forty-two, who had been deeply jaundiced for two years. At the end of fourteen months this peculiar change in the integument began to show itself on the eyelids, assuming a perfectly symmetrical form, as well as in the palms of the hands, where, as in my case, it followed accurately the flexures of the joints. The disease remained stationary till her death.

A second patient was admitted into Guy's Hospital, labouring under diabetes; but in this instance the eruption was so far different in its aspect that I cannot think Dr. Gull justified in associating it with the former case.

The third instance is that of a married woman, like the first, the subject of jaundice. The skin disease commenced at the end of fourteen months, appearing first on the hands, and subsequently affecting the eyelids. This case is now, I believe, under treatment, but the disease shows a tendency to increase rather than diminish.

The fourth case described by Dr. Gull is, in every respect, similar, both as to the prior existence of jaundice, and the distribution of the cutaneous deposit.

I have ventured to call attention to the above singular dis-